SUPPORTIVE HOUSING EVALUATION

TRAINING MANUAL FOR COUNTY EVALUATORS

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CHAPTER 1
INTRODUCTION

Background

It is estimated that one third of the people living on America's streets and in homeless shelters have a severe mental illness such as schizophrenia or manic-depressive disorder (Tessler 1989). The symptoms of severe mental illness are exacerbated by homelessness and since these symptoms affect nearly every aspect of life, including self-care, money management, family relations, etc., homeless mentally ill people often require a broad range of social services. Accessing social services that are located in separate agencies is especially difficult for these people (National Law Center on Homelessness and Poverty 1990; Task Force on Homelessness and Severe Mental Illness 1992; U.S. Conference of Mayors 1988). And, if they do access services, they are often seen as "non-compliant" to treatment and unlikely to return for follow-up appointments. However, efforts over the last decade and a half to reach this population have produced studies that show mentally ill clients who are homeless can be engaged and are willing to accept services if the services are integrated and the engagement process is tailored to their situation. Findings from the early National Institute of Mental Health (NIMH) McKinney demonstration projects identified several important factors, including the need for an engagement process that focuses on meeting the individual's basic needs for survival (e.g., food, housing), coordination and integration of services, and the need for a wide range of housing options (Dennis et al. 1991; Center for Mental Health Services 1994; Task Force on Homelessness and Severe Mental Illness 1992).

With the enactment of the Stewart B. McKinney Homeless Assistance Act in 1985, the federal government provided funding for supportive housing services for homeless individuals. California's Department of Mental Health (DMH) has been awarded federal homeless funds annually since 1985, initially through the Stewart B. McKinney Homeless Block Grant, and beginning in the state's fiscal year (SFY) 1991-92, through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. For the SFY 1998-99, the state's formula grant for PATH was increased by $700,000, with an additional $700,000 for SFY 1999-00. DMH committed these monies to fund additional supportive housing services.

The additional PATH funds, combined with Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds, were awarded to new programs in 13 counties. The funding is for a period of up to three years contingent upon the continued availability of federal funds. The counties are required to contribute matching funds in the amount of one dollar (in cash or in

kind) for every three dollars of federal funds provided. The 13 projects were selected from among 17 proposals submitted in response to a Request for Applications (RFA) issued in December 1998.

The RFA solicited proposals that encouraged innovative supportive housing projects for persons who have serious mental illness and are homeless or at imminent risk of becoming homeless. The proposals were reviewed in February 1999 and results were announced in March 1999. The 13 counties selected are Alameda, Contra Costa, Kern, Los Angeles, Monterey, Napa, Sacramento, San Joaquin, Santa Clara Santa Cruz, Shasta, Solano, and Yolo. A program evaluation is included as part of each demonstration project.

Description of the Projects

The thirteen projects share in common the provision of services that include case management, substance abuse counseling and vocational services. While all the projects recognize the importance of serving persons with a dual diagnosis of mental illness and substance abuse, two of the projects specifically target persons who have dual diagnosis. Two other projects will serve transitional age youth and three projects are located in rural counties. A brief description of each project is given below.

Alameda: This project will serve 55-90 ethnically diverse persons in a scattered site single room occupancy (SRO)and studios. The plan is to deliver culturally competent services based on a two-tier model. The first tier provides housing advocacy and placement and the second tier provides supportive services which include case management, mental & physical health treatment, substance abuse services, vocational/employment services, HIV counseling and services, on-site assistance with daily living skills, and social and recreational activities.

Contra Costa: This project will serve 75 clients in scattered sites. Units range from SRO to studios and one-bedroom apartments. The culturally competent services include case management, substance abuse services, money management, linkage with identified resources, life skills training, vocational services, assistance getting medical services, and money management.

Kern: This project will provide services to 90 clients in a single site SRO complex. Services include case management, medical and dental care, substance abuse counseling, money management services, linkage to identified resources, life skills training, education and vocational services. A non-profit outpatient medical clinic will make monthly visits to the housing complex to provide outpatient medical services. There will also be a consumer-run sheltered workshops on-site. this will consist of a cooperative nursery business.

Los Angeles: This project will provide supportive services to 50-100 individuals at scattered housing sites (apartments) in two specified areas. Services include

assessment, short-term case management, advocacy, dual diagnosis services, HIV/AIDS services, vocational services and training, and consultation and technical assistance to other service providers in the community.

Monterey: This project will provide housing for 37 clients in shared apartments. Each resident will have his/her own room. Services consist of crisis intervention, assistance in daily living, linkage and consultation with other agencies, individual therapy, vocational training, supported education, supported employment, day treatment, dual diagnosis services and representative payee services.

Napa: This project will provide services to 45 individuals in 35 apartments scattered throughout this rural county. Services include case management, crisis intervention, medication management, substance abuse services, social rehabilitation with an emphasis on daily living skills, vocational services and support groups.

Sacramento: This project will provide culturally competent services to 20 young adults, ages 18 to 25. The small number of clients is to allow the program to provide intensive services to a difficult-to-serve population, transitional age youth. The housing consists of scattered studies and one-bedroom apartments. Services are designed to increase participants' ability to live independently and become more integrated into the community. Staff will be available to residents on a 24-hour basis via pager. Other services include case management, mental health services, substance abuse treatment, education and vocational services and social and recreational activities.

San Joaquin: This project will serve 45 persons who have a dual diagnosis of serious mental illness and a concurrent substance abuse problem. The housing consists of 30 units in an apartment complex that has already been used by Shelter Plus Care clients with various disabilities including those of the target population. Services include case management, substance abuse services, linkage to other services, operation of a skills center, crises management, and vocational assistance.

Santa Clara: This project will provide culturally competent services to 24 persons in newly constructed SRO units. There is an office and program area on site. The services include case management, linkages to medical care, individual and group therapy, substance abuse services, social and recreational activities, vocational training, daily life skills assistance and training, and money management.

Santa Cruz: This project will provide housing with supportive services for 39 residents. This is a scattered site model. Culturally competent services include in-home vocational training, weekly house meetings, conflict resolution, vocational and educational services.

Shasta: This project to serve 50-70 people a year is located in a rural county. Some of the clients will be dually diagnosed. It is a scattered site model. Services include case management, benefits counseling, education and vocation services, substance abuse services, life skills services, and mental health services.

Solano: This project will serve 20-30 individuals in a scattered site model, primarily apartments, but some single-family dwellings are a possibility. Culturally competent services will include intensive case management, training in independent living skills, outpatient services, forensic services, vocational and employment services, medication compliance support, dual diagnosis recovery groups, and help in applying for financial assistance.

Yolo: This project will provide supportive housing services to approximately 10 transitional age youths each year in this rural county. The target is young adults age 18 to 25. Persons will not be required to move as they reach age 25 if they still require the program. Housing is a scattered site model consisting of a fourplex unit with two bedrooms each, up to three apartment units, and three single family residences. Total space will accommodate 24 residents. All residents must be SSI recipients. Services include mental health treatment, crises services, substance abuse services, day treatment, benefits procurement, representative payee services, educational support service, and vocational services.

Overview of Evaluation

The evaluation is nonexperimental. Clients will be administered assessment instruments at admission, annually, and at discharge. Data collected at admission will provide the baseline for assessing program effectiveness. These data will be collected by project staff.

There are three assessment instruments and one face sheet. These are discussed in detail in the following chapters, 4 through 7. At admission to the program, two of the assessment forms plus the Face sheet will be filled out. A year later, the Face sheet and all three assessment forms will be collected. This process will be repeated annually as long as the project continues and the client is participating in the program. When a client is discharged from the program, all four forms (face sheet plus three assessment instruments) should be completed. Data will be faxed to DMH on the day completed.

Participation by the client in the evaluation is voluntary. Clients will be asked to sign an informed consent-to-participate form. This consent is revocable, clients have the right to decline to participate at any point in the research.

Data collection on each project will be overseen by the county evaluator. The county evaluator is the key to the successful evaluation of the Supportive Housing Projects. The county evaluator will make sure that the data are collected on time

and the forms are completed correctly. DMH staff will complete the data analysis and program evaluation component.

Protecting Client Confidentiality

Protecting client confidentiality is very important. Client confidentiality will be protected by the use of a client identification (I.D.) number. This I.D. will be the client's county case number that is used to report data to the Consumer Information Services (CSI) Data base. None of the evaluation forms will contain the client's name, address, or date of birth. All forms will be linked by client I.D. number and date. Moreover, the clients' consent-to-participate forms will be kept separate from the clinical files in a locked cabinet.

Overview of Training Manual

The following chapters will provide the details about the evaluation and the data collection forms. Chapter 2 will provide an overview of the evaluation design. Chapter 3 will explain the procedures to inform the clients about the evaluation and gain consent to participate. Chapters 4 through 7 review the data collection instruments. Chapter 8 summarizes the responsibilities of the county evaluator. The appendices contain a list of county codes and a review of psychometric concepts..

References:

Center for Mental Health Services. 1994. "Making a Difference: Interim Status Report of the McKinney Demonstration Program for Homeless Adults with Serious Mental Illness." Rockville, MD: Department of Health & Human Services.

Dennis, Deborah L., John C. Buckner, Frank R. Lipton, and Irene S. Levine. 1991. "A Decade of Research and Services for Homeless Mentally Ill Persons." American Psychologist 46:1129-1138.

National Law Center on Homelessness and Poverty. 1990. "Social Security: Broken promise to America's Homeless." Washington, D.C.: National Law Center on Homlessness and Poverty.

Task Force on Homelessness and Severe Mental Illness. 1992. Outcasts on Main Street: Report of the Federal Task Force on homelessness and Severe Mental Illness. Washington D.C.: Interagency Council on the Homeless.

Tessler, R. C. and Dennis, D.L. 1989. A Synthesis of NIMH-funded Research Concerning Persons Who are Homeless and Mentally Ill. Rockville, MD: National Institute of Mental Health.

U.S. Conference of Mayors. 1988. Local Responses to the needs of homeless Mentally ill persons. Washington D.C.: U.S. conference of Mayors.

Chapter 2
Evaluation Design

Evaluation Design

The evaluation is non experimental. Clients will be administered assessment instruments at admission, annually, and at discharge. Data collected at admission will provide the baseline for assessing program effectiveness. These data will be collected by project staff.

There are three assessment instruments, one Face Sheet, and a Consent to Participate form. These are described briefly on Table 2.1 and in detail in chapters 3 through 7. All forms are in the public domain and there is no charge for using them.

TABLE 2.1 Brief Description of Required Housing Evaluation Forms

FORM	MEASURES	COMPLETED BY
California Quality of Life (CA-QOL)	family/social contact; spending money and adequacy of finances; victimization; arrests; general health status; satisfaction with general life situation, living situation, leisure activities, daily activities, family and social relations, finance, safety, and health.	Client
Kennedy Axis 5 (K Axis)	Client functioning in areas of psychological impairment, social skills, dangerousness, ADL-occupational skills, substance abuse, and medical impairment	Qualified Clinician
Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Satisfaction and overall perception of usefulness of program services; appropriateness of services; and outcomes of care	Client
Face sheet	Demographic background data, client living situation; project services provided to client	Project Staff
Consent to Participate	Informs clients of study goals, procedures, risks & benefits, and asks for participation	Client & Project Staff

Different assessment periods use different combinations of forms. As Table 2.2 indicates, at admission the consent form, the Face Sheet, the K Axis, and the CA-QOL will be collected. For the annual assessment, the Face sheet, the K Axis, the CA-QOL and the MHSIP Consumer Survey will be completed. At the time of discharge, the Face sheet, the K Axis, the CA-QOL and the MHSIP consumer Survey will be completed.

TABLE 2.2 Administration of Housing Evaluation Forms

ADMISSION	ANNUALLY	DISCHARGE
Consent to Participate		
Face sheet	Face sheet	Face Sheet
Kennedy Axis 5 (K Axis)	Kennedy Axis 5 (K Axis)	Kennedy Axis 5 (K Axis)
California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)
	Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Mental Health Statistics Improvement Program Consumer Survey (MHSIP)

The county evaluator will prepare the forms and give them to the project staff to complete. Within two months of admission to the program the Face Sheet, the Consent to Participate, and two of the assessment forms will be completed. A year later, the face sheet and all three assessment forms will be completed. The consent form is signed only once, at admission.

If the client declines to participate, he/she indicates this on the consent form and the staff will complete a Face sheet for the client. No other data will be collected on clients who decline to participate.

This process of annual data collection will be repeated as long as the project continues and the client is participating in the program. When a client is discharged from the program, the Face Sheet and the three assessment instruments should be completed.

If the client is unavailable for discharge data collection, the staff will complete just the face sheet for the client at the time of discharge. Data will be faxed to DMH on the day completed.

Other Data Elements

Several data elements will be collected from DMH's Client Service Information (CSI). This information will supplement the CA-QOL. This includes data on type of living situation when receiving services, types of productive activities client engages in and the number of days spent in productive activities.

Target Population

The target population for the demonstration projects are persons who have a serious mental illness and are homeless or at imminent risk of becoming homeless. Any client who enters the demonstration project may be included in the evaluation. There will be no selection of evaluation participants by the evaluation team.

Consent To Participate

Participation by the client in the evaluation is voluntary. At admission, clients will be asked to sign a Consent to Participate form which details the goals of the evaluation, study procedures, potential risks and benefits, the voluntary nature of participation, and steps to protect confidentiality. The consent is revocable, clients have the right to decline to participate at any point in the research. Clients also will be given a copy of the Project Evaluation Participant's Bill of Rights.

The decision to decline to participate in the evaluation is certainly influenced by how staff present the study to the clients. Staff should make it clear that the goal of the research is to evaluate services and that the client's input is critical since he/she is the one receiving the services and is the person best able to evaluate the services received.

Data Collection & Reporting

Data collection on each project will be overseen by the county evaluator. The county evaluator will make sure that the data are collected on time and the forms are completed correctly. It will be the county evaluator's responsibility to get the forms faxed on the day they are completed. Also, the county evaluator will ensure that only qualified staff administer the K Axis.

Data are to be faxed on the day collected. Forms are not to be held until a number are available for faxing. Faxing when finished insures data are not lost and lessens the work load for the Teleform system.

The completed forms will be kept in the client's file. The county evaluator will track the completion of each set of forms and the date faxed to DMH. This tracking system will be necessary when data do not reach DMH.

The data collection window for admission data is 60 days from the admission date. This means that the staff have 60 days from date of admission to complete

the administration of the forms. For the annual and discharge data collection, the window is 30 days before the annual date and 30 days after, for a total of 60 days.

Data Analysis

DMH staff will provide scored clinical profiles to project staff for sue in treatment. DMH staff will complete the data analysis and program evaluation component.

Responsibilities of County Evaluator

The county project evaluator is the key to the successful evaluation of the project. The county evaluators are responsible for a wide variety of tasks at the county level, from preparing the forms for staff use, to ensuring timely data collection. These responsibilities are reviewed in Chapter 8.

Obtaining Forms

All the forms, except for the K Axis, are in the public domain so there is no fee to purchase. DMH has received permission from Dr. James Kennedy to use the K Axis free of charge. A master copy of each form will be provided to the county evaluator. The county evaluator will make copies for the project. It is important that the copies be very clear and of high quality since the forms will be scanned by the Teleform system.

Chapter 3
Consent To Participate

General Information

Clients have the right to be informed of the goals of the study, to have the evaluation procedures explained, to be told about any possible benefits or risks expected from the evaluation, to be allowed to ask questions about the study, and to be allowed the choice to participate or not in the project evaluation. Clients will be informed of these rights when staff gives them a copy of the *Supportive Housing Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. This will be the first form to be completed for each new client.

Administration Procedures

The County Evaluator will give the *Consent to Participate* form and the *Supportive Housing Evaluation Participant's Bill of Rights* to staff along with the packet of the forms that are completed at admission. Within 60 days of admission, the client will be told about the evaluation and asked to participate in the Supportive Housing Project Evaluation.

Staff will give the client a copy of the *Supportive Housing Evaluation Participant's Bill of Rights*. The client may keep this copy. The staff will review each item with the client.

Next, staff will give the client the *Consent to Participate* form. Staff will review each of the items on the consent form. Staff will be explained to the client that she/he has the right to refuse to participate in the study. The client must be told that if he/she refuses to participate in the study, this will not affect his/her ability to receive services from the Supportive Housing Project.

Once it is clear that client understands the rights, the staff will ask the client if she/he wants to participate. If the client agrees to participate, the client will sign and date the form, and the staff will sign as a witness and date it as well.

Declines to Participate

If a client declines to participate, the staff will write across the bottom of the form, "Declines" and the client will be asked to sign <u>next</u> to the handwritten "Declines." Note that a client that is declining does <u>not</u> sign on the client's signature line; to sign on that line gives consent. Staff will sign and date the forms of clients who decline.

Maintaining Consent Forms

Since the Consent to Participate contains the client's name, the form will not be forwarded to DMH. The county evaluator will keep all the Consent To Participate forms in a single file. This file may be examined from time-to-time by the DMH state evaluator. When the file is examined, the county evaluator will obscure the names of clients, thus protecting client privacy.

Obtaining Forms

The State DMH will provide a clean copy of the *Supportive Housing Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. The county evaluator will make clear copies to distribute to staff.

SUPPORTIVE HOUSING EVALUATION
PARTICIPANT'S BILL OF RIGHTS

Any person who is asked to consent to participate as a client in the Supportive Housing Evaluation, or who is asked to consent on behalf of another, has the following rights:

1. To be told what the study is trying to find out.

2. To be told the procedures to be followed in the evaluation and whether any of the procedures are different from those which are carried out in standard practice.

3. To be told about the risks, adverse effects, and discomforts which may be expected.

4. To be told of any benefits the participant may expect from participating.

5. To be told of other choices available and how they may be better or worse than being in the study.

6. To be allowed to ask any questions concerning the study both before consenting to participate and at any time during the course of the study.

7. To be told of any medical treatment available if complications arise.

8. To refuse to participate at all, either before or after the study has begun. This decision will not affect any right to receive standard services.

9. To receive a signed and dated copy of the consent form and the Bill of Rights.

10. To be allowed time to decide to consent or not to consent to participate without any pressure being brought by the investigator or others.

CONSENT TO BE A RESEARCH PARTICIPANT IN
_____ COUNTY'S SUPPORTIVE HOUSING EVALUATION STUDY

Goal of Study

The goal of the evaluation is to measure how effective the Supportive Housing Project is at improving your symptoms, functioning, and the overall quality of your life. (Name of county evaluator) and the State Department of Mental Health are conducting this evaluation. You have been asked to take part in this evaluation because you are receiving services from the Supportive Housing Project. The study will last three years.

Study Procedures

If you agree to participate, this is what will happen:

1) The project staff will provide the evaluators with demographic information about you (e.g., gender, ethnicity), background information, and information about services received from the Supportive Housing Project. This information will not include your name but will contain a client I.D. which will identify your information for the evaluation.
2) You will be asked to fill out the California Quality of Life form. This form asks you to rate your satisfaction with several aspects of your life. This will form takes approximately 20-30 minutes to complete. This form will be sent to the evaluators. Again, it will not give your name, but will use a client I.D. number.
3) A mental health clinician will assess your mental health symptoms and provide this information to the evaluators. Again, the form will not contain your name but will use your client I.D. number
4) After you have been in the program for a year, you will be asked to fill out a consumer satisfaction form in order to find out if you are satisfied with the services you are receiving in the Supportive Housing Project. Again, the form will not contain your name but will use your client I.D. number. This forms takes approximately 10 minutes to complete. This form will be mailed directly to the State Department of Mental Health evaluator.
5) Every year that you are in the project, you will be asked to fill out all the forms and project staff will provide background information to the evaluators. Again, the forms will not contain your name but will use a client I.D. number.
6) This same information, with the exception of consumer satisfaction survey, is collected routinely when you receive mental health services. The only difference is that this information will be collected together with the same information from other clients of the supportive housing project in order to evaluate the services that are being provided.

Risks

The primary risk to you from participating in the study might be that someone not on the evaluation team might see confidential information about you. For example someone might see the forms you complete. To protect against this, we are using a client I.D. number instead of your name. Also, the consumer satisfaction form you fill out will be mailed directly to the State Department of Mental Health Evaluator so that any critical

comments you make about the services received in the Supportive Housing Project will not be read by project staff. This information will be put together with information from other clients in the project and shared with project staff in a summary form so that comments cannot be linked to any individual.

You may experience some discomfort (such as anxiety or frustration) when asked personal questions. Staff will assist you if you become upset by such questions.

Potential Benefits

Your participation in the evaluation may benefit you by providing treatment and services in a more efficient and timely manner. The information you provide may benefit you by helping staff understand you better. Your comments may help improve the services provided. Your participation in the evaluation may not benefit your directly, but the information may be helpful in planning and reviewing the types of services provided to others in the future.

Questions

If you have other questions or evaluation related problems, you may contact (name of county evaluator) at (telephone number).

Voluntary Participation

Participation in this evaluation is entirely voluntary. You may refuse to participate or withdraw form the evaluation at any time. If you choose not to participate, your refusal will have no effect on your ability to receive services from the Supportive Housing Project.

Confidentiality

Evaluation information will be kept separate from any other records. You will be assigned a client I.D. number which will be used for all of the study information and will protect your confidentially to the extent provided by law. This Consent-to-Participate form will be kept by county evaluator, (name of county evaluator). It may be reviewed by the state evaluator but no one else will have access to this information.

Consent

Your signature below gives your consent to participate in the Supportive Housing Evaluation study. It also confirms that you have been given a copy of the "Research Participants Bill of Rights" that describes your rights as a participant in this study. If you decline to participate, please write "Decline" across the bottom of the page & your initials.

_____ _____

Client's signature Date Print Name

_____ _____

Legal Representative if necessary Staff witness signature Date

Chapter 4
Face Sheet

General Information

The Face sheet is the second form that will be completed for a client. This form will provide background information about the client, including ethnicity, gender, current living and employment situation. It will also ask for information about services the client has received from the Supportive Housing Project. The Face sheet will be filled out for each client that consents to participate. For clients that do not consent to participate, part of the Face sheet will be filled out (details described below).

The Face sheet will be completed for each client at admission, annually thereafter, and at discharge. At admission, data on the demographic characteristics of the client will be collected, as well as data on client's primary mental health diagnosis, employment status, and housing status. At subsequent administrations (annually and at discharge) data on the client's primary mental health diagnosis will be collected again, along with information on services received from the supportive housing project. Demographic data will only be collected at admission. Each time the Face sheet is completed, it will be faxed to the State DMH for automated entry into a computerized database.

Development

The Face sheet was developed specifically for the Supportive Housing Projects. It was designed to get basic information on each client without creating a heavy work load for project staff. It is designed to use the Teleform system which will speed data analysis.

Administration Procedures

The Face sheet will be completed at every data collection. Before the Face sheet is given to the staff to complete, the county evaluator will enter the correct client identification (ID) number, county code, distribution date, form linking number, and assessment type in the appropriate fields. These items are described below.

County number: Enter the county number. This number is the CDS/CSI identification number. See appendix B for a list of county numbers. Enter the number in the boxes and then mark the appropriate circles.

Distribution Date: Next, the evaluator should complete the field "Distribution Date" This date, along with client ID and form linking number, is used to link the forms for any given assessment. This date is the date the forms are given to the

staff, not the date the forms were completed. This date must be the same on all of the forms for a given administration. For example, at admission all three forms (Face sheet, K Axis, and Ca-QOL) must have the same distribution date. The evaluator will write the distribution date in the boxes and then fill in the corresponding circles.

Assessment Type: The evaluator will mark the appropriate circle for "Assessment Type." At admission, the evaluator will mark "Admission." At the annual review (yearly after admission), the evaluator will mark "Annual." When the client is discharged, the evaluator will mark the "Discharge" circle. Note that some clients may decline to participate when asked. The evaluator has no way of knowing this. Thus, the item "Refused to participate" will never be filled out by the evaluator. Project staff will mark this choice if a client declines, and erase the assessment choice marked by the evaluator.

Client ID: This is the county case number for the client as reported to CDS/CSI. The client's ID number be written in the boxes under "Client ID Number" and then the appropriate circles should be marked below. It is critical that this number be correct

Form Linking Number: At the bottom of each page is a row of nine boxes. The evaluator will fill these boxes with the client's ID number.

After these fields are completed, the evaluator will give the Face sheet, along with the other forms that must be completed, to the project staff for completion. The Face sheet will be completed by project staff within 60 days of the client's entering the program. Staff will be responsible for completing the rest of the Face sheet. These items are described below.

Assessment type revisited: If a client declines to participate, project staff will mark this choice on the assessment type and erase the assessment type marked by the county evaluator. This is the only time that project staff will complete Assessment type. The staff will then complete the rest of the demographic items (age, ethnicity and age), and the GAF Score and Primary Diagnosis items. No other information on the Face sheet will be completed. This information will permit the state DMH to describe the characteristics of those that refuse to participate to see if they differ significantly from those that participate. No other data will be collected on those that decline and no additional forms (e.g., discharge) will be completed.

Client Gender: Client's gender refers to client's self-identification. Staff will fill in the appropriate bubble for gender. Note that gender is only collected once, at admission. On subsequent data collections, gender and the other demographic information (i.e., age, ethnicity) will not be collected when completing the annual and discharge face sheets.

GAF Score: The client's most recent GAF score as noted in mental health records should be entered in the boxes under "GAF Score" and the circles filled in.

Client's Primary Diagnosis: The client's primary diagnosis should be obtained from mental health records. This should reflect the most current diagnosis. The staff should choose the most appropriate diagnosis and fill in the appropriate circle.

Client Age: The client's age should be age at the time of scheduled administration (i.e., distribution Date). Staff will enter the age in the boxes and fill in the circles below with the number. Note: this is only completed once, on the admission Face sheet.

Client Ethnicity: The client's ethnicity should be based on client's self identification. Staff should fill in the appropriate bubble for ethnicity. Like other demographic characteristics, this is only completed on the first Face sheet, at admission.

Employment status: Staff will choose the one of the four employment statuses that most closely describes client's current employment status. Current refers to employment status at the time of scheduled administration (i.e., distribution Date). This information will be completed by staff every time a face sheet is filled out.

Project Services: This item will be completed annually and at discharge. The section is not completed at admission. Staff will select the item that most closely describes the services the client has received from the Supportive Housing Project up to the time of the data collection and complete the appropriate circles.

Previous Living Situation: On the admission Face sheet, staff will skip this item. On the annual and the discharge Face sheets, the staff will select the description that best describes the client's living situation in the prior year and enter the appropriate letter in the box under "Previous Living Situation."

Current Living Situation: Staff will select the description that best describes the client's living situation at the time of administration of the form (i.e., distribution date) and enter the appropriate letter in the box under "Current Living Situation." Note that if the client has not changed his/her living situation since the last assessment, both current and previous living situation items will be coded the same.

Previous Tenancy Status: On the admission Face sheet, staff will skip this item. On the annual and the discharge Face sheets, the staff will select the status that

best describes the client's previous tenancy status and fill-in the corresponding circle.

Current Tenancy Status: Staff will select the description that best describes the client's current tenancy status and fill-in the corresponding circle. Current refers to the client's status at the time of the scheduled administration (i.e., distribution Date).

Faxing Forms to DMH

On the day the Face sheet is completed, staff will fax it to the State DMH Teleform number, 916-654-3178. Note that this FAX number is just for Teleform instruments.

Obtaining Forms

The State DMH will provide a clean copy of the Face sheet to the county evaluator. The county evaluator will make clear copies of the Face sheet to distribute to staff.

Housing Face Sheet

COUNTY CODE

DISTRIBUTION DATE

ASSESSMENT TYPE

- ○ Admission
- ○ Annual
- ○ Discharge
- ○ Refused to participate

CLIENT ID NUMBER

CLIENT GENDER

- ○ Male
- ○ Female

GAF SCORE

CLIENT AGE

CLIENT ETHNICITY

- ○ White/Caucasian
- ○ Hispanic
- ○ African American
- ○ Asian
- ○ Filipino
- ○ American Native
- ○ Other
- ○ Unknown

CLIENT'S PRIMARY DIAGNOSTIC CATEGORY

- ○ Schizophrenia and other Psychotic Disorders
- ○ Mood disorders (i.e., major depressive or bipolar disorders)
- ○ Anxiety/Other Diagnoses

Form Linking Number

Client Employment Status (choose one)

○ **Client is employed in the competitive job market**
If yes, approximately how many hours per week:
○ 1-10 ○ 11-20 ○ 21-34 ○ 35 or more

○ **Client is employed in the noncompetitive job market (sheltered workshop, protected environment)**
If yes, approximately how many hours per week:
○ 1-10 ○ 11-20 ○ 21-34 ○ 35 or more

○ **Client is not in the job market. Client is (choose one)**
- ○ Actively looking for work
- ○ Homemaker
- ○ Student
- ○ Volunteer Worker
- ○ Retired/on disability
- ○ Resident/inmate of institution
- ○ Other
- ○ Client employment status is unknown

Services client has received from this Supportive Housing Project since the last assessment (if admission assessment, skip this section):

○ Housing Services
○ Referral to community mental health services
○ Screening and diagnostic services
○ Referrals to drug/alcohol treatment services
○ Client declined any services
○ Case Management services
○ Planning for/referral to housing
○ Assistance in applying for housing
○ Helped client obtain housing (e.g.,assistance in filling out lease agreement; help w/deposit)
○ Assistance in maintaining housing (e.g., assistance to prevent eviction)

Form Linking Number

Client's Previous Living Situation
(Select code from list below)
(If admission, skip this i' .m)

Client's Current Living Situation

A House or apartment (include trailers, hotels, dorms, barracks, etc.)
B House or apartment and requiring some support with daily activities
C House or apartment and requiring daily support and supervision
D Supported housing
E Foster family home
F Group Home (includes levels 1-12 for children)
G Residential Treatment Center (includes levels 13-14 for children
H Community Treatment Facility
I Board and Care
J Adult Residential Facility, Social Residential Facility, Crisis Residential, Traditional Residential, Drug Facility, Alcohol Facility
K Mental Health Rehabilitation Center (24 hour)
L Skilled Nursing Facility/Intermediate Care Facility, Institute of Mental Disease (IMD)
M Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs Hospital
N State Hospital
O Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
P Homeless, no identifiable residence
Q Other
U Unknown/Not reported

Previous Tenancy Status
(at time of last assessment; if admission, skip this item)

○ Continuing
○ Evicted due to lease violations
○ Left voluntarily
○ Other
○ Unknown

Current Tenancy Status
(at time of this assessment)

○ Continuing
○ Evicted due to lease violations
○ Left voluntarily
○ Other
○ Unknown

Form Linking Number

Page 3 of 3

Chapter 5
Kennedy Axis 5
(K Axis)

General Information

The Kennedy Axis 5 (K Axis) is a clinician-rated instrument measuring general client functioning in seven areas. These areas are 1)psychological impairment; 2)social skills; 3)violence; 4)ADL-Occupational skills; 5)substance abuse; 6)medical impairment; 7)ancillary impairment. Ratings can range from 0 to 100. In addition to an individual score for each of the subscales, a patient profile can be generated using the K Axis. This score is equivalent to the Global Assessment of Function (GAF) Scale.

The K Axis will be administered by a qualified clinician at admission, annually thereafter, and at discharge. The qualifications needed are discussed below, in the section on scoring. The county evaluator will have the responsibility to ensure that only qualified staff complete the K Axis.

Development

The K Axis is a refinement of the Kennedy Axis V developed by Dr. James Kennedy, at the Massachusetts Department of Mental Health. The K Axis was developed as a tool for capturing and profiling the clinician's impressions of the client's overall level of functioning in seven areas.

Psychometrics

The psychometric properties of the K Axis are assumed to be acceptable since the psychometric properties of the original Axis V Subscales are acceptable. The psychometric properties of the original Axis 5 were examined during the pilot testing phase of another DMH study, The Adult Performance Outcome Pilot Study, and found acceptable. See appendix B for a review of psychometric concepts.

Reliability: For the original Axis V Subscales, inter-rater reliability was not assessed since the pilot methodology did not allow for independent verification of inter-rater reliability, but the author (Dr. Kennedy) indicated that inter-rater reliability was good if raters received a reasonable amount of training.

Validity: Data from the pilot study and from the author report that the Axis 5 has predicative validity, content validity, construct validity, and face validity.

Differential Functioning: Differential functioning was noted for the Axis 5 since the instrument did produce statistically significant (.05 level) differences between groups when they were examined by age, gender and diagnosis.

Sensitivity to Change: The Axis 5 showed sensitivity to change on just one of the seven subscales between the first and second administration of the form in the pilot study.

The subscale which measures psychological impairment showed statistically significant improvement from the first to second administration when the data were combined. However, no other subscale changes were statistically significant. When the data were stratified by diagnosis, the psychological subscale showed a statistically significant increase between the two administrations.

Since the K AXIS is a minor revision of the Axis 5, it is assumed that the psychometric properties will be similar.

Scoring

The K Axis is based on the Axis V of the DSM-IV and the GAF score. Scoring is done by a qualified clinician. A qualified clinician is defined as:

- Licensed Clinicians
- Paraprofessionals in the behavioral sciences who are overseen by licensed or licensed waiver staff. Paraprofessionals would be those individuals with a bachelor's degree in psychology or a related field, and at least 3 units of graduate-level work in each of these areas: Testing/assessment; Abnormal Psychology; Personality Theory; and Counseling Psychology.
- Licensed Practitioner of the Healing Arts (MD, LCSW, MFCC, Licensed Psychologist, RN)
- Waivered staff (MFCC, LFT, LCSW)
- Psychologist Interns

The clinician will meet with the client and review the client's mental health file before completing the K Axis. On each subscale the clinician will review the anchor point descriptions and, based on their clinical evaluation, select the "best fit" for the client. The scales range from 0 (extremely low functioning) to 100 (superior functioning). The clinician will enter the number for each score in the subscale rating boxes on the scoring sheet.

On two items, numbers one and five, the clinician will also score the client's level of impairment on those items (psychological and Substance Abuse).
Finally, the clinician will sign and date the form.

In addition to the individual score for each of the subscales, a patient profile can be generated using the K Axis, as well as a score equivalent to the Global Assessment of Functioning (GAF) scale.

The K Axis instruction sheet and a copy of the K Axis Teleform scoring sheet are included at the end of this chapter.

Clinical Utility
The K-Axis is a structured valid and reliable way for collecting data on the clinicians impression of client's functioning. This information is useful in planning treatment, measuring its impact, and in predicting outcomes.

Administration Procedures
The county evaluator will prepare the K Axis scoring sheet by filling in the distribution date, the client I.D. number, and the county code. The method for completing these items is described in Chapter 4, in the section "Administration Procedures." The county evaluator will give the K Axis to the qualified clinician for completion.

The clinician will meet with the client to assess the client. The clinician has 60 days from the date of admission to complete the form.

Overlap with Performance Outcome Project
The K Axis is being used for the Performance Outcome project so it is possible that a client will have a recently completed K Axis in file. If the same clinician has completed a K Axis for the client within 30 days of the distribution date, the clinician can copy the scores onto the Supportive Housing Teleform sheet. If the K Axis has been done by a different clinician, then the project clinician will assess the client and complete the K Axis.

Discharged Client Unavailable
There will be times when a client is discharged because she/he has left the program without advance warning and is not available to meet with the clinician for assessment for the K Axis. Some of these clients will simply disappear, others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the K Axis will not be collected.

Faxing Forms to DMH
On the day the K Axis is completed, the clinician will fax the it to the State DMH Teleform number, 916-654-3178.

Obtaining Forms
The State DMH will provide a clean copy of the K Axis form to the county evaluator. The county evaluator will make clear copies to distribute to staff.

KENNEDY AXIS V

"Kaxis"

(SUBSCALES FOR AXIS V)

By: James A. Kennedy, MD

Draft 05/01/99

"Powerful Tool for Capturing and Profiling your Clinical Impressions."

INSTRUCTION SHEET (Draft 05/01/99)

What Is the Kennedy AXIS V (Kaxis)? The Kaxis consists of seven subscales for Axis-V. These subscales capture the clinician's impression of the individual's overall "Level of Functioning" in the following areas:

1) Psychological Impairment 2) Social Skills 3) Violence 4) ADL-Occupational Skills
5) Substance Abuse 6) Medical Impairment 7) Ancillary Impairment

In addition to an individual score for each of the subscales, a patient profile can be generated using the Kaxis, as well as, a score equivalent to the Global Assessment of Functioning (GAF) Scale. This information is useful in planning treatment, measuring its impact, and in predicting outcome.

Note: If needed, **Each Subscale Can Stand Alone** and act as an individual questionnaire.

Using the KENNEDY AXIS V to Create Equivalents to the GAF Scale

- GAF-Equivalent (GAF-E): Adding up the first four subscales and dividing by four should give a score that is roughly equivalent to the GAF Scale. This should assure that the major areas of functioning are not overlooked when making the rating.
- Dangerousness Level (DL): The DL is roughly equivalent to the GAF's measure of dangerousness. The numbers used to derive the DL are located on the Scoring Sheet directly below each Subscale score. The lowest of these numbers becomes the DL. If the DL is 50 or less, it is often associated with the need for very high intensity outpatient care, residential care or even hospitalization.

Current, Discharge, and Highest Level of Functioning Ratings

- The **Current Rating** should be based on the level of functioning at the time of the evaluation and is most reflective of the current need for treatment or care.
- The **Discharge Rating** should be based on the level of functioning at the time of discharge and, when compared to the admission rating, is most reflective of the impact of treatment.
- The **Highest Level of Functioning** should be based on the highest level of functioning that lasted for at least a few months during the last year. This score may be very predictive of outcome.

"Best Fit" Aids in Capturing the Clinical Impression

The rating that is chosen should be guided by the **Best Fit** for the client, even though some of the thinking and/or behaviors at that level **May Not Be Characteristic of the Client.** The anchor points only serve as aids and are not required for a specific rating. Ultimately, the **Clinical Impression** is the determinant of the score and the **Best Fit** should guide one to that score, rather than a particular anchor point.

Each Subscale Measures Multiple Factors

In each subscale, rate the factor that causes the most impairment. On the "Violence" subscale the best fit should be based on **Suicidal Factors for the Suicidal Client** and on factors related to **Assaultiveness for the Assaultive Client.** On the "Substance Abuse" subscale the best fit should be based on use of **Alcohol for the Alcoholic** and use of **Drugs for the Drug Abuser.** Impairments in multiple factors should help confirm a lower rating.

Factors that relate to being withdrawn, showing lack of interest or poor motivation should be rated under "Psychological Impairment" rather than being rated under "Social Skills" or "ADL-Occupational Skills."

Effects of Treatment, Stress, Physical Limitations, Etc.

- **The Presence or Absence of Support, Medication, Other Treatments, or Even Severe Stress Generally Should Not Affect the Rating, Unless They Are Covering Up Skills.** The rating should be based on the level of functioning and no adjustment should be made for the presence or absence of these factors. Do not factor out effects of treatment, even if the patient may drop out of treatment.
- **The Effect of Physical/Environmental Limitations Generally Should Be Factored Out of the Rating.** For example, factor out not abusing drugs or not assaulting others due to being incarcerated or physically restrained; factor out not being socially active or employed due to physical constraints of being in a wheelchair or being confined to bed. Rate how functional, or dysfunctional, a client would be, if given reasonable opportunity, i.e., don't let physical barriers cover up skills or violence.

PSYCHOLOGICAL IMPAIRMENT (1)

100 Superior Psychological Functioning/Coping, no psychological impairment; life's everyday problems never seem to lead to any significant anxiety or depression. **No Symptoms.**

90 Absent or Minimal Symptoms (e.g., mild anxiety before an exam), good psychological functioning in all areas; interested and involved in a wide range of activities; generally satisfied with life; no more than everyday problems or concerns.

80 If Symptoms Are Present, They Are Transient and Expected Reaction to Psychosocial Stressors (e.g., upset by breakup with girlfriend; difficulty concentrating after family argument; mild preoccupation with problems; a woman has many friends, functions extremely well at a difficult job, but says "The stress is too much."); not considered to have mental problems by those who know him/her.

70 Some Mild Symptoms (e.g., depressed mood with mild insomnia, occasional truancy, theft within the household, difficulty trusting others, mild insensitivity to the feelings and needs of others), but generally functioning fairly well; however, those who know him/her well might express some concerns about his/her mental state.

60 Moderate Symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks; frequently preoccupied; moderate impairment in attention span); moderate insensitivity to the feelings and needs of others; to those who know him/her well it is clear the he/she has mental problems.

50 Serious Symptoms (e.g., moderately depressed mood, moderate lethargy, severe obsessional rituals, severe phobia, severe sexual perversion, moderate problems with anorexia/bulimia, frequent shoplifting, frequent anxiety attacks, moderately guarded, mild but definite manic syndrome).

40 Major Psychological Impairment; some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant; moderate paranoia; may have hallucinations or delusions; however, probably realizes they are not a part of reality); major impairment in several areas, such as judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is not motivated to work or moderate negative symptoms of schizophrenia); even to those who do not know him/her well would likely consider him/her to have mental problems.

30 Behavior Is Considerably Influenced by Delusions or Hallucinations; appears to be responding to hallucinations; serious impairment in communication or judgment (e.g., sometimes incoherent, thinking is grossly inappropriate); severely depressed mood; withdrawn with few spontaneous communications; inability to function in almost all areas (e.g., stays in bed all day and does not care for own living space; no job, home, or friends due to paranoia, poor motivation, social withdrawal, extremely poor insight and/or being almost totally insensitive to the feelings and needs of others); at times attention span is markedly impaired; **Severe Sociopathic Behaviors Have Lead to Multiple Arrests;** severe sexual perversion toward prepubescent children.

20 Gross Impairment in Thinking and Communication; manic excitement or catatonia; largely incoherent or mute; generally markedly impaired attention span; occasionally fails to maintain minimal personal hygiene due to severe lethargy or very disorganized, bizarre thinking (e.g., too lethargic to attempt to wipe food off one's shirt; smears feces for bizarre, delusional reasons).

10 Thinking Is Totally Disorganized; totally insensitive to the feelings and needs of others; completely incoherent; completely mute, extremely catatonic; persistent inability to maintain minimal personal hygiene or minimal safety due to totally disorganized thinking or **Very Severe Lethargy;** unable to focus attention for even a few seconds; chronic, self-induced vomiting has lead to a very life threatening situation.

NR Not Rated

SOCIAL SKILLS (2)

100 **Superior Social Skills;** is sought out by others because of his or her outstanding social/communication skills; has many friends and no difficulty making new friends. **No Symptoms.**

90 **Good Social Skills;** no difficulty being pleasant and engaging; good communication skills; **Socially Effective.**

80 **No More Than Slight Impairment in Social Skills;** slightly inappropriate social behavior leads to infrequent interpersonal conflicts; no more than slight difficulty maintaining several friendships.

70 **Some Difficulty with Social Skills** (e.g., mild difficulty knowing how to share with others, show sympathy for others and/or understand feelings of others); social skills are not obviously impaired; generally functioning fairly well; has some meaningful interpersonal relationships.

60 **Moderate Difficulty with Social Skills** (e.g., conflicts with peers due to inappropriate teasing or other inappropriate social behavior; attempts to be pleasant and engaging are usually moderately awkward; moderate difficulty knowing what to say even when talking with friends; moderate difficulty knowing how to share with others, show sympathy toward others and/or understand feelings of others); **Hardly Any Friends Because of Problems with Social Skills;** communications are understandable but vague.

50 **Serious Impairment in Social Skills; Has No Friends Because of Clearly Impaired Social Skills; However, Has Some Peer Relationships, Despite Social Skills Being Clearly Impaired;** frequent conflicts with peers or co-workers because of inappropriate social behavior; conversations are often socially inappropriate; great difficulty communicating thoughts and feelings; unable to introduce self and a second person without clear difficulty; frequently intrusive; inappropriate, non-sexual touching.

40 **Major Impairment in Social Skills; Attempts to Approach Others Quickly Leads to Embarrassing Situations;** no friends and virtually no peer relationships because of poor social skills; unable to appropriately engage in almost any social activity; continually intrusive with little understanding of the inappropriateness of the behavior; major acts of socially inappropriate behavior **Leads to Being Assaulted,** being fired from work or expelled from school; **Great Difficulty Recognizing or Coping with Inappropriate Sexual or Aggressive Advances by Others;** great difficulty recognizing that his/her sexual advances are not welcome.

30 **Acts Grossly Inappropriately Toward Others;** virtually no understanding of the feelings of others, how to share with others and/or how to show sympathy toward others; conversations with others are grossly inappropriate; unaware of or ignores most social norms as manifested by openly masturbating, inappropriate sexual touching, etc.

20 **Very Few Social Skills;** generally unable to communicate in an organized, understandable way, uses short phrases or gestures to get basic needs met; acts very shockingly inappropriate in front of others, such as smearing of feces or making sexual advances toward young children; however, may have some understanding that such behavior is inappropriate.

10 **Few If Any Social Skills;** unable to communicate in an organized, understandable way; shows no apparent awareness of social norms (e.g., doesn't realize that it is inappropriate to grab food or cigarettes from others); **Extremely Vulnerable to Victimization** (e.g., has no understanding of the inappropriateness and/or dangers of approaching strangers or assaulting others; needs constant care and supervision to prevent client from getting into dangerous social situations).

NR Not Rated

VIOLENCE (3)

100 **No Evidence of Violence** to self or others; very satisfied with life; life's problems never seem to lead to any inappropriate anger, frustration or conflicts. **No Symptoms.**

90 **No Significant Evidence of Violence** to self or others; generally satisfied with life, no more than everyday problems or conflicts (e.g., an occasional argument with family members).

80 **No More Than Slight Problems** with anger and irritability; if symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., occasional "blow-up" with family members or friends; mild anger after family argument); no suicidal ideation.

70 **Mild Symptoms** (e.g., mild problems with anger and irritability; occasional thoughts of violent behavior; thoughts that life may not be worth living); symptoms are not interfering significantly with client's functioning; **Severely Assaulted Others or Serious Suicidal Attempt Over Five Years Ago;** however, for years, has had no significant problems with violence or self-harm.

60 **Moderate Difficulty with Anger and Irritability** (e.g., moderate conflicts with peers or co-workers due to anger and hostility; occasional threats of violent behavior); some evidence that self-destructive thoughts may be present. **Murdered Someone Over Ten Years Ago;** however, for many years, has had no significant problems with violence.

50 **Serious Problems with Anger and Irritability;** moderate threats of violence; becomes verbally threatening when needs/demands are not immediately met or when pushed to do something; **Occasionally Hits Someone; Occasional, Relatively Minor, Sexual Assault; Occasional Suicidal Ideation;** non-suicidal self-abuse, such as burning self with cigarettes or cutting self superficially; not felt to be a real danger of seriously hurting self or others; however, some precautions including close observation may be indicated.

40 **Major Problems with Anger and Irritability; Some Real Danger of Hurting Self or Others;** violent outbursts toward family and neighbors; frequent threats of violence; hitting or biting someone is not unusual; occasionally difficult to redirect from aggressive behavior; induces much fear of physical assault in others; **Single Suicidal Gesture Within the Last Month;** moderate suicidal ideation; actively making plans to hurt self or others; set a relatively minor fire within the last three months or is having fire setting impulses with history of setting one or two minor fires.

30 **Often Hitting or Biting Others;** becomes physically aggressive when needs are not immediately met; suicidal attempt without clear expectation of death during the last month; frequent suicidal preoccupation; actively following through with plans to hurt self or others (e.g., obtaining a gun, pills, rope, etc.); **At Times Close Observation or Restraints May Be Necessary to Prevent Serious Harm to Self or Others.**

20 **Frequently Violent;** very real danger of hurting self or others; serious thoughts of killing someone; attempted to viciously harm or viciously rape someone within the last month; **Constant Suicidal Preoccupation; However, Client is Felt to Have Some Control of the Suicidal Impulses;** two or more suicidal attempts without clear expectation of death within the last month; close observation to prevent harm to self or others may be required 1 or 2 days a week.

10 **Persistent Danger of Severely Hurting Self or Others;** attempted to kill someone within the last month; attempted to viciously harm or viciously rape a child within the last month; set a fire within the last month with intent of hurting others; serious suicidal attempt within the last month with clear expectation of death; **Little or No Control of Impulses to Hurt Self or Others;** expressing loss of control of command hallucinations to hurt self or others; 1-to-1, at arms length observation and/or physical restraint for prevention of serious harm to self or others may be required 3 or more days a week; **Murdered Someone Within the Last Two Years.**

NR Not Rated

ADL-OCCUPATIONAL SKILLS (4)

100 **Superior ADL-Occupational Skills in a Wide Range of Activities** (e.g., in school, on the job, as a homemaker, pursing a complicated hobby); superior workmanship; work challenges never seen to get out of hand; is sought out by others because of his or her work skills. **No Symptoms.** Skills are consistent with that expected of a successful college graduate.

90 **Good Skills in All ADL-Occupational Activities;** no more than average difficulties with any work assignment. Absent or minimal symptoms. Skills are consistent with that expected of a successful high school graduate.

80 **No More Than Slight Impairment in Occupational Skills or Skills in School;** having slight difficulty performing at an average level; slight difficulties with routine chores, work assignments or schoolwork assignments; slight impairment in workmanship.

70 **Mild Difficulty with Occupational Skills or Skills in School** (e.g., minor difficulty following instructions, workmanship is somewhat sloppy), **But Generally Functioning Fairly Well.**

60 **Moderate Difficulty with Occupational Skills or Skills in School** (e.g., probably employed; however, has trouble carrying through assignments; some difficulty problem solving or following instructions; some difficulty driving a car; some difficulty knowing how to budget money; some difficulty maintaining a home or apartment).

50 **Serious Impairment in Occupational Skills or Skills in School** (e.g., unable to keep a job from more than a few weeks due to poor occupational skills; almost failing in school; moderate difficulty following instructions; moderately sloppy workmanship); needs supervision when shopping for food; some difficulty using public transportation; some difficulty preparing self a reasonable, family-style meal; some difficulty ordering, eating properly, tipping, etc. in a regular restaurant; some difficulty making a long distance phone call.

40 **Major Impairment in Occupational Skills or Skills in School** (e.g., unable to work at a job for any significant period or do routine housework due to poor work skills; failing in school due to poor academic skills); needs supervision to use public transportation; mild to moderate difficulty ordering and eating in a fast food restaurant; poor understanding of how to budget money.

30 **No Job and Unable to Independently Maintain a Home** due to serious impairment in skills needed to perform ADLs and tasks at home; serious difficulty following instructions; needs some supervision to prepare simple meals for self, such as a sandwich and beverage; needs supervision to dress self, make a local phone call, follow a very simple self-medication procedure; needs constant supervision to complete more complicated ADLs (e.g., operating a washer and dryer); very sloppy workmanship; some difficulty responding appropriately to a fire alarm; difficulty finding way back from short errands.

20 **Gross Impairment in Skills Needed to Perform ADLs and Tasks at Home** (e.g., needs some supervision to maintain minimal personal hygiene; is almost totally unable to follow simple instructions; needs supervision to feed self; **Unable to Function Independently** (e.g., needs constant supervision to complete most simple tasks; does not know the value of money; unable to dial 911 in an emergency; unable to find way back from short errands).

10 **Demonstrates Almost No ADL Skills** (e.g., is totally unable to follow instructions; unable to complete most tasks even with constant supervision; may even have to be physically assisted to complete a task, including eating or dressing. **Persistent Inability to Maintain Minimal Personal Hygiene;** considerable external support (e.g. nursing care and supervision) is needed to prevent client from accidentally harming self (e.g., wandering into traffic, danger of seriously burning self when attempting to cook or when smoking); unable to appropriately respond to a fire alarm.

NR Not Rated

SUBSTANCE ABUSE (5)

100 **No Significant Problems with Drugs or Alcohol;** no use or almost no use of alcohol; NON-SMOKER; no use of street drugs; never abuses substances, even when life's problems get out of hand; is an example of someone who is totally free of problems with substance abuse. **No Symptoms.**

90 **No More Than the Average Problems and Concerns with Alcohol;** minimal use of alcohol; social drinker; no use of illegal drugs; **History of Serious Alcohol or Drug Abuse with Over Ten Years of Sobriety and Minimal, If Any, Treatment Needed to Maintain Sobriety.**

80 **No More Than Slight Impairment;** drinks to mild intoxication about once a month; **Smokes Cigarettes Daily;** experiments with marijuana less than once a year; some mild abuse of over-the-counter medications and/or caffeine; no more than slight impairment in social, occupational, or school functioning due to substance abuse (e.g., temporarily falling behind in schoolwork); **Serious Alcohol or Drug Abuser with Over Five Years of Sobriety with Minimal Treatment Needed to Maintain Sobriety.**

70 **Mild Impairment in Social, Occupational or School Functioning Due to Substance Abuse,** but generally functioning fairly well; drinks to mild or moderate intoxication 1 or 2 days a week; excessive prescription drug seeking; experiments with drugs such as marijuana, Valium, Ativan, Librium once or twice a year. **Heavy Smoker; Unable to Quit Cigarettes Despite Numerous Attempts.**

60 **Moderate Difficulty in Social, Occupational or School Functioning Because of Substance Abuse** (e.g., substance abuse results in moderate impairment in job performance and/or conflicts with peers or coworkers); drinks on a regular basis, often to excess; drinks to moderate intoxication more than 2 days a week; occasionally experiments with drugs such as cocaine, Quaaludes, Amphetamines (speed), LSD, PCP (angel dust), inhalants; moderate abuse of over-the-counter medications and/or caffeine; **Unable to Quit Cigarettes Despite Chronic Medical Complications; Serious Alcohol or Drug Abuser with Less Than Two Years of Sobriety.**

50 **Serious Symptoms; Behavior and/or Lifestyle Is Considerably Influenced by Substance Abuse;** moderate drug/alcohol seeking behavior; often intoxicated when driving or when working; abusing substances despite being pregnant; unable to keep a job; marriage failing or failing school due to abuse of alcohol or marijuana; one alcohol or drug related arrest; stealing prescription pads and/or altering or forging prescriptions; moderate daily use of drugs such as marijuana, Valium, Ativan, Librium; occasionally injects drugs into skin or muscle; has a morning drug or drink to get going; uses narcotics other than heroin or cocaine on a fairly regular basis; frequently abuses over-the-counter medications and/or caffeine; **Use of Alcohol or Drugs (Other Than Cigarettes) Is Beginning to Cause Some Medical Complications.**

40 **Major Impairment in Several Areas Because of Substance Abuse** (e.g., alcoholic man avoids friends, neglects family, and is unable to get a job; student is failing in school and having serious conflicts with his family or roommate due to substance abuse); occasionally injects heroin or cocaine in one's veins; occasionally has an accidental drug overdose; **Severe Alcohol or Drug Abuser with Less Than One Month of Sobriety.**

30 **Drugs or Alcohol Pervade One's Thinking and Behavior; One's Behavior Is Considerably Influenced by Substance Abuse;** injection of heroin or cocaine into one's veins once or twice a day; abuses substances without regard for personal safety (e.g., some accidental overdoses and/or auto accidents resulting in medical hospitalizations); blackout spells; prostitutes self for drugs/alcohol; multiple alcohol or drug related arrests; serious neglect of children due to substance abuse.

20 **Functioning Is Extremely Impaired by Daily Use of Drugs Such As LSD, PCP, Cocaine, Heroin, or Inhalants;** unable to go for more that a few hours without significant physical and/or psychological craving for drugs or alcohol; **Continued Use of Alcohol or Drugs (Other Than Cigarettes) Is Beginning to Cause Very Serious Medical Complications** (e.g., liver failure, overt brain damage, AIDS or high risk for AIDS); **Injection of Drugs into One's Veins More Than Twice a Day.**

10 **Client's Life Is Totally Controlled by Drugs or Alcohol;** continually in a state of intoxication or withdrawal; at extremely high risk of seizures or DTs due to withdrawal; continually seeking drugs or alcohol; numerous alcohol or drug related arrests; **Clear Evidence That Drugs or Alcohol Will Lead to Severe Physical Harm or Death;** numerous instances of drug related accidents or accidental overdoses resulting in frequent medical hospitalizations; **Life Threatening Neglect of Children Due to Substance Abuse.**

NR Not Rated

MEDICAL IMPAIRMENT (6)

100 **Superior Medical Health;** physical exam and laboratory tests are normal, including no significant weight problem; illnesses never seem to affect him or her; few if any problems with even common medical problems (e.g., colds, headaches, indigestion, constipation, diarrhea); virtually never has to miss work or school due to medical problems; exercises regularly; on no medication, except may take a prophylactic medication, such as a multivitamin; doesn't wear glasses/contacts; **No Significant Medical Problems or Symptoms.**

90 **Good Medical Health;** has few if any medical problems; physical exam and laboratory test reveal no more than minor abnormalities; illnesses seldom seem to affect him or her; average difficulties with common medical problems (e.g., colds, headaches, indigestion, constipation, diarrhea); wears glasses/contacts that correct minor visual problems; wears dentures; only occasionally misses work or school due to medical problems; occasionally needs OTC medication.

80 **IF Medical Problems Are Present, They Are Transient and Cause Minimal Impairment In Social, Occupational or School Functioning;** somewhat more than average missing work or school due to medical problems; impairment in mobility, use of hands or hearing that is **Totally Corrected** by the use of a prosthesis, hearing aids, etc.; mild obesity or mild emaciation; occasional urinary incontinence due to organic problems.

70 **Mild Medical Problems Which May Cause Some Difficulty in Social, Occupational or School Functioning;** however, generally functioning fairly well; missing no more than about one to two weeks a year from work or school due to medical problems; mild impairment in mobility, speech, use of hands, vision or hearing despite use of prosthesis, glasses, hearing aids, etc.; chronic illness, however, has few if any overt signs or symptoms of the illness (e.g., mild asthma, mild hypertension, mild diabetes, mild arthritis; mild dysphagia; epilepsy easily controlled with medication; mild tardive dyskinesia); requires medical follow-up several times a year; taking prescription medication on a daily basis.

60 **Moderate Difficulty in Social, Occupational or School Functioning Due to Medical Problems;** missing no more than about one month a year from work or school due to medical problems (e.g., moderate asthma, moderate hypertension, moderate diabetes, moderate COPD, mild to moderate hyponatrenia secondary to polydipsia, HIV positive, chronic hepatitis, mild cerebral palsy, mild cystic fibrosis, mild hemophilia, mild angina on exertion); medical problems requiring daily or weekly monitoring and treatments beyond p.o. medications (e.g., injections, blood levels, nebulizer, physical therapy); needs bladder bag.

50 **Serious Impairment in Social, Occupational or School Functioning Due to Medical Problems;** serious impairment in mobility, speech, use of hands, vision or hearing despite use of prosthesis, glasses, hearing aids, etc.; considered a serious risk for falling; only partially controlled epilepsy; equipment is needed for mobility (e.g., wheelchair, portable oxygen); **Medical Problems Prevent One from Driving a Car.**

40 **Major Impairment in Several Areas** (such as work or school or family relations) because of medical problems; missing about two months a year or more from work or school due to medical problems; medical problems results in major impairment in mobility, speech, use of hands, vision, or hearing despite use of prosthesis, glasses, hearing aids, etc.; frequently confined to bed or wheelchair because of chronic medical problems.

30 **Behavior and/or Lifestyle Is Considerably Influenced by Medical Problems;** very serious medical problems confine one to bed or wheelchair most of the time (e.g., very symptomatic metastatic cancer, multiple sclerosis, cerebral palsy or AIDS); chronic failure of a major body system (e.g., heart, lung, kidney, liver); on dialysis for kidney failure.

20 **Major Medical Problems Confine One to Bed All of the Time** and intensive, continuous medical treatment is required without which one would rapidly progress to death (e.g., **Late Stages** of metastatic cancer, multiple sclerosis; AIDS, etc.); chronic, near terminal failure of a major body system (e.g., heart, lung, kidney, liver); quadriplegic.

10 **Chronic Medical Incapacity Requiring Basis Life Support** (e.g. respirator); removal of life support would rapidly lead to death; patient in chronic vegetative or near vegetative state; persistent delirium or coma.

NR Not Rated

ANCILLARY IMPAIRMENT (7)

100 **Superior Life Situation;** currently in or has ready access to ideal living environment (neighborhood, home, school, work, etc.); superior financial resources for his/her needs; no legal problems; extremely safe environment; **No Significant Ancillary Problems or Symptoms.**

90 **Good Life Situation;** has few if any ancillary problems; no more than minor problems with living environment, financial resources and/or legal problems, e.g., occasionally living environment doesn't fully meet one's needs, rare late payment on a bill, rare parking or traffic ticket.

80 **If Ancillary Problems Are Present, They Are Transient and Cause No More Than Minimal Difficulty with one's Living Situation, Financial Resources or the Law;** somewhat more than average problems with one's living environment, financial resources or legal problems.

70 **Mild Ancillary Problems, e.g., Some Difficulty in one's Living Environment, Financial Resources or with the Law;** mild difficulty paying bills/credit cards; mild difficulty with parking or traffic tickets; occasional mild verbal violence in one's environment; **However, Generally Safe Living Situation.**

60 **Moderate Difficulty with Living Situation, Finances or the Law;** high risk for being in a dangerous homeless or jail situation; criminal charges place one at high risk of incarceration; no stable residence and/or income, often having to move from one living situation to another; moderate difficulty paying bills/credit cards; **Evaluation and/or Disposition Is Being Made for Nonviolent Criminal Activity** (e.g., trespassing, stealing, defacing/destruction of property, or lewd behavior); **Evaluation and/or Disposition Is Being Made for Competency to Make Decisions Concerning Person, Estate and/or Treatment.**

50 **Serious Problems with Living Situation, Finances and/or the Law;** frequent risks or threats of moderate violence in one's environment; **Evaluation and/or Disposition Is Being Made for Relatively Minor, But Violent or Dangerous Criminal Activity,** (e.g., minor assault, threats to do physical harm, driving while under the influence, sexually touching someone or exposing oneself); **Serious Placement Difficulties, Even When Ready for Placement.**

40 **Major Problems with Living Situation, Finances and/or the Law; Some Real Danger of Being Physically Injured in one's Environment; Evaluation and/or Disposition Is Being made for Very Violent Criminal Activity** (e.g., vicious assault, attempted rape, attempting to molest a child, arson).

30 **Lifestyle Is Considerably Influenced by Ancillary Problems;** one is in a very dangerous homeless or jail situation most of the time; unable to obtain basic food, shelter and/or clothing; frequent, mild to moderate physical injuries from violence in one environment.

20 **Major Ancillary Problems (e.g., One Is in a Very Dangerous Homeless or Jail Situation All of the Time);** at times one's life is at serious risk due to lack of resources for basic food, shelter and/or clothing or because of high level of violence in one's environment; **Evaluation and/or Disposition Is Being Made for Extremely Serious Criminal Charges** (e.g., attempted murder, vicious rape, viciously molesting a child).

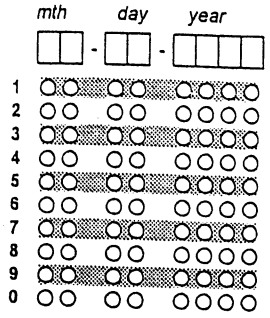
10 **Living/Financial Situation Is Totally Inadequate;** one's life is continually at serious risk due to lack of basic food, shelter and/or clothing or because of extremely high level of violence in one's environment; **Evaluation and/or Disposition Is Being Made for the Most Extreme Charges of Violence** (e.g., murdering anyone, very viciously harming or very viciously raping a child, arson with intent of hurting others).

NR Not Rated

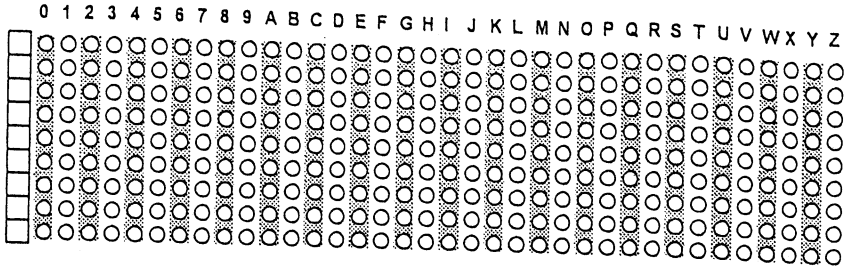
KENNEDY AXIS V: SCORING SHEET

Distribution Date

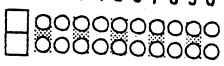
mth *day* *year*



Client ID Number



County Code 1 2 3 4 5 6 7 8 9 0



1) Psychological Impairment

Primarily (check one)

O Not Impaired O Antisocially Impaired O Other Impairment O Both

Subscale Rating

2) Social Skills

Subscale Rating

3) Violence

Primarily (check one)

O Not Impaired O Antisocially Impaired O Other Impairment O Both

Subscale Rating

4) ADL-Occupational Skills

Subscale Rating

5) Substance Abuse

Primarily (check one)

O Not Impaired O Antisocially Impaired O Other Impairment O Both

Subscale Rating

6) Medical Impairment

Subscale Rating

7) Ancillary Impairment (optional)

Subscale Rating

Clinician's Signature:_____Date_____

Chapter 6
California Quality of Life
(CA-QOL)

General Information

The California Quality Of Life (CA-QOL) measures the client's satisfaction with his or her quality of life. The eight domains covered include general life satisfaction, living situation, daily activities & functioning, family, social relations, finances, legal & safety, and health. The form is designed to be completed by the client in approximately 20 minutes.

Development

The CA-QOL was developed in response to a need in another DMH project (The Adult Performance Outcome Pilot Study) for a self-administered quality of life assessment instrument in the public domain. A self-administered version of the widely used Lehman's Quality of Life was in development but was not in the public domain. DMH obtained permission from Dr. Lehman to select and modify items from two of his instruments, Lehman's Quality of Life Long Interview and Lehman's Quality of Life Brief Interview. A committee composed of representatives from California's Department of Mental Health, County Mental Health programs, California mental Health Planning council, and additional consultants was formed to develop a short self-administered quality of life assessment instrument. The CA-QOL was constructed statistically from items in Lehman's two instruments. After its development, the form was pilot tested. The CA-QOL, in combination with information from the state DMH CSI system, measures the same domains as Lehman's self-administered form (Lehman's QOL-SF).

Psychometrics

The psychometric properties, reviewed during the pilot testing for the Adult Performance Outcome Pilot Evaluation, are acceptable. See Appendix B for a review of psychometric concepts.

Reliability: The overall reliability of the CA-QOL is high (.93). The reliability of all CA-QOL subjective scales is relatively high (.84 to .93), while the reliability of the three Ca-QOL objective scales with more than 1 item is modest (.67 to .75). The reliability coefficients of the same three objective subscales are also modest (.73 - .76).

Validity: The CA-QOL was developed from two of Lehman's Quality of Life forms and these two forms have demonstrated validity. By extrapolation, the CA-QOL is assumed to be valid.

Differential Functioning: An analysis of subscale scores by demographic category indicated statistically significant differences at the .05 level. These differences, although significant, were deemed minor because they accounted for only 10% of the variance.

Diagnoses combined: When all diagnoses were combined, statistically significant differences were found, but these were minor.

Within Diagnoses: When stratified by diagnoses, statistically significant differences were found. For Diagnosis 1 (Schizophrenia/Psychotic Diagnoses), there were significant differences for the category age on two scales: "General Life Satisfaction" and "Satisfaction with Living Situation." Post hoc tests did not pinpoint these differences as explained above; However, the youngest and oldest groups had higher mean scores than did the intermediate age categories.

For Diagnosis 2 (Mood Disorders) there were statistically significant differences on three objective scales. Differences were found for age for "Amount of Spending Money." Clients in the youngest age category reported having less money to spend on themselves than did clients in the other age categories. There were also differences on "Adequacy of Finances." The youngest and oldest age categories reported having the least money for various items. It is possible that these differences could be an artifact of low numbers.

There was a meaningful difference found for ethnicity on "General Health Status." Although post hoc tests did not pinpoint these differences, Asians tended to have the highest mean scores and Caucasians the lowest mean scores. It is possible that these differences could be an artifact of low numbers.

Scoring

Scoring of the CA-QOL is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7 point scale. Objective items use a variety of formats. Scale scores can be computed for each types. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales can be found in the "Scoring Manual for the California Quality Of Life," which is included at the end of this chapter.

Clinical Utility

The CA-QOL provides as relatively brief, structured way to assess self-reports of the quality of life for persons with severe mental illness. The instrument provides both an objective measure about a quality of life indicator as well as the client's subjective feelings of satisfaction about that indicator. The CA-QOL results can provide useful information for assessment and treatment planning, e.g., assessing a client's satisfaction with qualify of life, developing a baseline for satisfaction with quality of life, etc.

Administration Procedures

The CA-QOL is completed at every data collection, i.e., at admission, yearly and at discharge. The County evaluator will complete the top portion of the form by filling in the fields for "Client ID Number," "Distribution Date," and "County Code." Also, the "Form Linking Number " i.e., client I.D., should be entered in eight of the boxes at the bottom left hand corner of each page of the form. The method for completing these items is described in Chapter 4, under "Administration Procedures." After this is done, the County Evaluator will give the form to project staff so they can give it to the client.

Within the first 60 days following admission, project staff will give the CA-QOL to the client to complete. This form takes approximately 18 minutes for clients to complete on their own. In the pilot test, 60% completed the instrument without assistance, approximately one quarter required some assistance (23%), and 15% required total interviewer administration.

When the client has completed the form, the staff will fax it to DMH on the day it is completed.

Overlap with Performance Outcome Project

The CA-QOL is being used for the Performance Outcome project so it is possible that a client will have a recently completed CA-QOL in file. If the CA-QOL has been completed for the client within 30 days of the distribution date, the staff may, if they want to, copy the scores onto the Supportive Housing Teleform sheet. The Teleform sheets for different projects are not interchangeable.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the CA-QOL. Some of these clients will simply disappear, others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the CA-QOL will not be collected.

Faxing Forms to DMH

On the day the CA-QOL is completed, staff will fax it to the State DMH Teleform number, 916-654-3178.

Obtaining Forms

The State DMH will provide a clean copy of the CA-QOL Teleform to the county evaluator. The county Evaluator will make clear copies to distribute to staff.

Scoring Manual

for the

California Quality of Life (*CA-QOL*)

Prepared by the California Department of Mental Health
Research and Performance Outcome Development Section

Table of Contents

Tables

ACKNOWLEDGMENTS

The California Department of Mental Health would like to express its appreciation to the California Mental Health Directors Association and the California Mental Health Planning Council for their support and assistance in the development and implementation of the Adult Performance Outcome System, of which this manual is a part. Additionally, we would like to express our gratitude to the leadership, staff, and mental health consumers of Sacramento and San Mateo counties for their assistance in the development of the California Quality of Life (*CA-QOL*) Survey. We would also like to thank Dr. Anthony Lehman, Department of Psychiatry, University of Maryland, for his permission to use items from his public domain quality of life instruments in order to develop a survey instrument particularly suited to California's needs.

For more information about the *CA-QOL* contact:

California Department of Mental Health
Research and Performance Outcome Development Unit
1600 9th Street
Sacramento, California 95814

Scoring Manual for the California Quality of Life

I. BACKGROUND

Introduction

Under the leadership of the State Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the California Mental Health Directors Association (CMHDA), a pilot project was conducted to assess instruments for use in California's Adult Performance Outcome System. The recommendation that resulted from this pilot was that the following instruments be selected for statewide implementation: the Global Assessment of Functioning (*GAF*) Scale, the Behavior and Symptom Identification Scale (*BASIS-32*), a quality of life survey instrument, and a consumer satisfaction program evaluation instrument.

Further meetings regarding a quality of life instrument resulted in the selection of the
QL-SF (formerly called the *TL-30S*), Dr. Anthony Lehman's shorter, self-administered quality of life instrument. Additionally, in order to respond to subsequent questions about the availability and cost of the *QL-SF* and to provide greater flexibility to the counties, the DMH, CMHPC, and CMHDA agreed to develop an alternative, self-administered, public domain quality of life instrument (the California Quality of Life or *CA-QOL*). If the *CA-QOL* proved sufficiently comparable to the *QL-SF*, counties could, at their discretion, choose to use either quality of life instrument for the Adult Performance Outcome System.

Development of the *CA-QOL*

DMH obtained written permission from Dr. Lehman to select and modify items from his public domain Quality of Life Interview Instruments (*QOL-Brief* and *QOL-Long*) in order to develop a new quality of life instrument particularly suited to California's needs. A small committee of representatives from DMH, CMHPC, and CMHDA then developed a draft of the new quality of life instrument, the *CA-QOL*, extracting items from both the *QOL-Brief* and *QOL-Long*.

The *CA-QOL* consists of 40 items and measures the same domains as the *QL-SF* when supplemented with information from DMH's Client Services Information (CSI) data system. In order to minimize the data collection burden on counties, while measuring the CMHPC domains, the committee agreed to obtain as much data as possible from the CSI system.

Pilot Methodology

Two counties (Sacramento and San Mateo) volunteered to administer both quality of life instruments to a sample of seriously mentally ill adult mental health clients. The counties attempted to obtain a heterogeneous sample with particular emphasis on obtaining adequate numbers of both men and women. Information was also gathered on the client's ethnicity and age, as well as primary diagnosis within broad categories. Categories of diagnosis found to be useful in the previous pilot were: (1) schizophrenia and other psychotic disorders, (2) mood disorders, and (3) anxiety and other diagnoses. Pilot protocols were developed and distributed before the counties began administering the instruments. These protocols addressed clinician training, instrument administration issues, and data collection and reporting issues

Pilot Results

Both instruments were administered in a rotated order to a sample of 198 seriously mentally ill adult mental health clients. In general, pilot participants included adequate numbers within age categories, major ethnic groups, gender, and the two major diagnostic categories to allow for statistical analysis. There was little missing data.

Most client participants were able to complete either of the instruments without assistance (approximately 60%). Approximately 23% of the clients required some assistance and only about 15% required total interviewer administration. On average, it took clients 20 minutes to complete the *QL-SF* and 18 minutes to complete the *CA-QOL*. The range of reported times for both instruments was from about five minutes to as long as one hour. Approximately 75% of the clients were able to complete either instrument in 20 minutes or less, and approximately 90% of the clients were able to complete either instrument in 30 minutes or less. Completion times for both instruments could vary considerably depending on the client's level of functioning.

In general, average scores on corresponding scales were quite similar and correlated well. An analysis of scale scores by demographic category indicated only minor statistically significant differences.

Based on an internal consistency measure of reliability (Cronbach's alpha), the overall reliability of the *CA-QOL* was found to be high (.93), while the overall reliability of the *QL-SF* was lower (.70). The reliability of the three *CA-QOL objective* scales with more than one item was modest, as was the reliability of the same three *QL-SF* objective subscales. The reliability of all *CA-QOL subjective* scales was relatively high. The reliability of *QL-SF* subjective scales can only be computed for the two items which make up the "General Life Satisfaction" scale, and it was slightly lower than for same two items on *CA-QOL*. Internal

consistency coefficients of reliability cannot be computed for any other *QL-SF* subjective scales since the other scales have only one item.

Both instruments were based on Lehman's *QOL-B and QOL-L* instruments which have demonstrated validity and reliability. By extrapolation, it is assumed that the *QL-SF* and *CA-QOL* are valid. Additionally, the instruments are assumed to be valid for purposes of the California Adult Performance Outcome System because they measure what they are supposed to measure; i.e., the CMHPC quality of life domains.

For more detailed information on statistical results, a copy of the summary report entitled "A Pilot to Evaluate Alternative Quality of Life Assessment Instruments", can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

Conclusions of Pilot

In many ways the instruments are similar:

- Both instruments provide a relatively brief, structured way to assess the quality of life of persons with severe mental illness.
- Both instruments are based on Lehman's public domain quality of life instruments and, as a result, item content and format are similar.
- When combined with the CSI data system, both instruments adequately measure the quality of life domains which are of interest to the CMHPC.
- The completion time required and assistance needed were similar for both instruments.
- There was little differential impact within scales of either instrument.
- Mean scores are quite similar for corresponding scales, and correlations between these scales are generally high. No meaningful differences were found between scale scores across instruments. Scores from the *QL-SF* can be statistically equated to those on the *CA-QOL* using regression techniques.

In some ways the CA-QOL has advantages for California:

- The *CA-QOL* is in the public domain. This not only eases the financial burden on counties, but makes it possible to revise the instrument's format or develop language translations to meet California's needs.

- An analysis of the psychometric properties of the *CA-QOL* indicates it compares very favorably with the *QL-SF*. It is somewhat faster to complete, and its overall and scale reliability based on internal consistency is better.

- The *CA-QOL* minimizes the data collection burden on counties, while still measuring the CMHPC domains, by obtaining as much data as possible from California's CSI data system. However, although this eliminates redundant questions, it also limits the instrument's usefulness for national comparisons because certain data elements are missing.

- Although both instruments, when combined with CSI data, measure the same CMHPC domains, the *CA-QOL* provides more complete information of the subjective, client satisfaction scales.

The purpose of the pilot was to determine whether the *CA-QOL* and *QL-SF* could be equated and to analyze the psychometric properties of the two instruments. After a review of the initial pilot results, the conclusion of this project is that the *CA-QOL* can serve as a valid alternative to the *QL-SF*. Additional data are still being gathered and will be appended when they are available.

II. GENERAL GUIDELINES

Clinical Integration

The key to the successful implementation of the adult performance outcome measurement system is effective clinical integration of the performance outcome instruments. The
CA-QOL is one part of a set of instruments. The information provided by the set of outcome instruments can furnish valuable clinical information. However, unless clinicians understand how to interpret and integrate this information into the diagnosis, treatment planning, and service provision process, the data will not be used effectively.

The results of the adult performance outcome instruments are not intended to replace the skills used by clinicians to complete a thorough evaluation, design a treatment plan, or monitor progress. Many of the questions are similar to the questions clinicians already ask as part of their clinical assessment. However, asking these questions in a standardized format, in combination with clinical assessment skills and additional data sources, gives a more comprehensive and objective clinical profile of an individual client.

Uses

The *CA-QOL* results can provide useful information for assessment and treatment planning (e.g., assessing a client's satisfaction with quality of life, developing a baseline for satisfaction with quality of life, identifying areas of strength or weakness, and developing a treatment plan). The *CA-QOL* results can also be useful for monitoring/evaluating progress, identifying a need for additional resources, and evaluating the effectiveness of treatment.

Administration

The *CA-QOL* should be administered along with the other assessment instruments at intake (once a client has been determined to be part of target population), yearly, and at discharge. The Adult Performance Outcome Training Manual gives more specific information on administration procedures for the adult performance outcome instruments. A copy of the Adult Performance Outcome Training Manual can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

As indicated earlier, the *CA-QOL* was intended to be administered as a self-report, but the pilot found that assistance may be required. This assistance does not necessarily have to be provided by the clinician.

III. SCORING THE *CA-QOL*

Scoring of the *CA-QOL* is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales are listed in Table 6.1 below. *Note*: scoring of the alternate quality of life instrument, the *QL-SF*, is also relatively simple. Counties selecting the *QL-SF* can obtain a scoring manual by contacting Deborah Rearick of HCIA/Response at (781) 522-4630 or writing HCIA/Response Technologies at
950 Winter Street, Waltham, MA, 02451.

Missing Data

Scale scores should not be computed if there are any missing data for that scale. Because most scales are composed of no more than two or three items, even a

single non-response to the items in that scale significantly affects an aggregated score.

Subjective Scales

All of the items measuring subjective scales use the same 7-point ordinal scale. Respondents should mark only one answer for each item. Items should be coded as indicated in Table 6.1.

Table 6.1
Coding for Subjective Scales

Subjective Scales	Items	Coding for Subjective Items
General Life Satisfaction Satisfaction with Living Situation Satisfaction with Leisure Activities Satisfaction with Daily Activities Satisfaction with Family Relationships Satisfaction with Social Relations Satisfaction with Finances Satisfaction with Safety Satisfaction with Health	1, 17 2a, 2b, 2c 3b, 3c, 3d 3a 6a, 6b 8a, 8b, 8c, 8d 11a, 11b, 11c 14a, 14b, 14c 16a, 16b, 16c	1 = Terrible 2 = Unhappy 3 = Mostly Dissatisfied 4 = Mixed 5 = Mostly Satisfied 6 = Pleased 7 = Delighted

In order to obtain the scale score, simply compute the average of all of the items listed next to each scale. For example, for the scale "Satisfaction with Living Situation", assume that a consumer marks a score of **4** on Item 2a, a score of **5** on Item 2b, and a score of **6** on Item 2c. The average of these three scores would be the sum of 4 + 5 + 6 (which is 15) divided by 3 for an average (mean) score of 5. "Daily Activities" is the only area in which an average cannot be computed since it consists of only one item.

Objective Scales

As mentioned previously, certain objective categorical information necessary to measure CMHPC outcome domains is already being gathered by the CSI data system and was not included in the *CA-QOL*. These two areas are: Type of Living Situation and Types of Productive Activities (e.g., work, education, volunteering). The *CA-QOL* does gather subjective information about these domains. The items measuring the remaining seven objective scales come in a variety of formats and should be coded as described in Table 6.2. As noted previously, these items can be scored individually or combined into scale scores where appropriate (for scales with more than one item).

Note that item number 13 (number of arrests) and item number 15 (health status) are coded so that higher values are a negative outcome. On all other items, higher values indicate a positive outcome.

Table 6.2
Coding for Objective Scales

Objective Scales	Items	Coding for Objective Items	Scale Scores
Frequency of Family Contacts	4, 5	0 = no family 1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean (excluding those responding 0)
Frequency of Social Contacts	7a, 7b, 7c, 7d	1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean
Amount of Spending Money	9	1 = less than $25 2 = $25 to $50 3 = $51 to $75 4 = $76 to $100 5 = more than $100	Single score
Adequacy of Finances	10a, 10b, 10c, 10d 10e	0 = No 1 = Yes	Compute percent yes/no
Victim of Crime	12a, 12b	0 = No 1 = Yes	Compute percent yes/no
Arrested	13	0 = 0 arrests 1 = 1 arrests 2 = 2 arrests 3 = 3 arrests 4 = 4 arrests 5 = 5 arrests 6 = 6 arrests	Single score Note: for this item high scores are a negative outcome.
General Health Status	15	1 = excellent 2 = very good 3 = good 4 = fair 5 = poor	Single score

California Quality of Life (CA-QOL)*

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

County

0 1 2 3 4 5 6 7 8 9

Instructions: **Below is a set of questions about your life. Please answer each question by filling in the bubble that best describes your experience or how you feel. Please fill in only one bubble for each question.**

General Life Satisfaction

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Living Situation

2.Think about your current living situation. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The privacy you have there?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The prospect of staying on where you currently live for a long period of time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Daily Activities & Functioning

3.Think about how you spend your spare time. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The chance you have to enjoy pleasant or beautiful things?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of fun you have?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of relaxation in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

*Adapted from the Full and Brief versions of the Lehman Quality of Life Interview.

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Family

4. In general, how often do you talk to a member of your family on the telephone?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

5. In general, how often do you get together with a member of your family?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all
- ○ no family

6. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you and your family act toward each other?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The way things are in general between you and your family?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Social Relations

7. About how often do you do the following?

A. Visit with someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

B. Telephone someone who does not live with you?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

C. Do something with another person that you planned ahead of time?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

D. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?

- ○ at least once a day
- ○ at least once a week
- ○ at least once a month
- ○ less than once a month
- ○ not at all

8. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The things you do with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The amount of time you spend with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The people you see socially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of friendship in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

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Finances

9. On average, how much money did you have to spend on yourself in the past month, not counting money for room and meals?

○ less than $25 ○ $25 to $50 ○ $51 to $75 ○ $76 to $100 ○ more than $100

10. During the past month, did you generally have enough money to cover the following items?

	No	Yes
A. Food?	○	○
B. Clothing?	○	○
C. Housing?	○	○
D. Traveling around for things like shopping, medical appointments, or visiting friends and relatives?	○	○
E. Social activities like movies or eating in restaurants?	○	○

11. In general, how do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The amount of money you get?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How comfortable and well-off you are financially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of money you have available to spend for fun?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Legal & Safety

12. In the past month, were you a victim of:

	No	Yes
A. Any violent crimes such as assault, rape, mugging, or robbery?	○	○
B. Any nonviolent crimes such as burglary, theft of your property or money or being cheated?	○	○

13. In the past month, have you been arrested or picked-up for any crimes?

○ *0 arrests* ○ *1 arrest* ○ *2 arrests* ○ *3 arrests* ○ *4 arrests* ○ *5 arrests* ○ *6 or more arrests*

14. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How safe you are where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The protection you have against being robbed or attacked?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

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Health

15. In general, would you say your health is:

○ excellent ○ very good ○ good ○ fair ○ poor

16. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. Your health in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. Your physical condition?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. Your emotional well-being?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Global Rating

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
17. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

18. How did you become involved with this program?

○ **I decided to come in on my own.**

○ **Someone else recommended that I come in.**

○ **I came in against my will.**

The California Quality of Life Survey (CA-QOL) is adapted from Dr. Anthony Lehman's Quality of Life Interview (Full and Brief versions) by a committee representing the State Department of Mental Health, California Mental Health Directors Association, and the California Mental Health Planning Council with the written permission of Dr. Lehman. Questions about the CA-QOL should be directed to the California Department of Mental Health, 1600 9th Street, Sacramento, CA, 95814. For more information about the Lehman Quality of Life Interview, contact: Anthony Lehman, M.D., Department of Psychiatry, University of Maryland Medical Center, 645 West Redwood Street, Baltimore, MD 21201.

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CHAPTER 7
MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM (MHSIP) CONSUMER SURVEY

General Information

The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is a public domain instrument that was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program community, and the Center for Mental Health Services. The MHSIP Consumer Survey measures the client's general satisfaction with program services, access to services, appropriateness of treatment, and outcomes of care. The form is designed to be completed by the client in approximately 10 minutes.

Development

The original 40-item MHSIP Consumer Survey was piloted by five states. Based on guidance from the NCQA Behavioral Measurement Advisory Panel, a shorter 21-item version of the instrument was developed. The reduced item set was obtained by using an algorithm that selected items on the basis of their unique contribution to a domain in combination with logical and exploratory factor analytic procedures. DMH added 4 questions to the 21-item form. These included changes in wording to make it more applicable to the California setting and the addition of certain items important to consumers, resulted in a 26-item version.

Psychometrics

The MHSIP Task Force has reported that the 21-item version has psychometric features similar to the original 40-item version. In the five state study, the reliability coefficients for the domain scales ranged from .65 to .87. The 26 item version is expected to have similar psychometric properties. See appendix B for a review of psychometric properties.

Scoring

Respondents rate their level of agreement or disagreement with each of the first 26 statements on a scale with values ranging from strongly agree to strongly disagree, and not applicable. The average percentage score for each domain is calculated (domains are access, appropriateness, outcomes and satisfaction with services) and these scores are used to compare programs on these measures. Table 7-1 shows the items that are scored for each domain.

TABLE 7.1 MHSIP CONSUMER SURVEY DOMAINS

DOMAINS	ITEM NUMBERS
Access	4, 5, 6, 7, 8, 19
Appropriateness	9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Outcomes	20, 21, 22, 23, 24, 25, 26
Satisfaction	1, 2, 3,

Clinical Utility

The MHSIP Consumer Survey is not a clinical instrument. It can provide valuable information about clients views on program services.

Administration Procedures

The MHSIP Consumer Survey will be completed after one year in the program yearly thereafter, and at discharge. If a client discharges before spending one year in the program, the MHSIP should be completed.

Before giving the form to the client, the county evaluator will write the client identification number, the county code and distribution date in the appropriate fields. The form finking number (i.e., client I.D.) will be entered in the boxes at the bottom left of each page of the form. The method for completing these items is described in Chapter 4, under "Administration Procedures." Also, an envelope should be addressed to Candace Cross-Drew, State of California, Department of Mental Health, Research & Evaluation, 1600 9th Street, Sacramento, CA 95814. The envelop should include postage so that the client will not have to pay for mailing the survey to DMH.

Staff will give the survey and envelop to the client. The client will be informed that responses on the MHSIP Consumer Survey are completely confidential and the state evaluator at DMH will not release any individual data to the county. Staff will explain that all MHSIP Consumer Survey responses from the county will be aggregated and reported back to the county and service providers in summary form. To encourage accurate responses, it is crucial that respondents to the MHSIP Consumer Survey be assured of the confidentiality of their responses.

The client will be told that when she/he has completed the form, she/he should put the survey into the envelop and mail it.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the MHSIP Consumer Survey. Some of these clients will simply disappear, others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the MHSIP Consumer Survey will not be collected.

Faxing Forms to DMH

The MHSIP Consumer Survey is the only form that will not be faxed to DMH. It should be mailed. The client will put the form in a preaddressed and stamped envelop and mail it.

Overlap with Performance Outcome Project

The MHSIP Consumer Report is being used by the Adult Performance Outcome project so it is possible that a client recently will have completed a MHSIP Consumer Report rating her/his mental health services. Since the Supportive Housing Project is separate from mental health services, the client will be asked to complete another MHSIP Consumer Report for the Supportive Housing Project.

Obtaining Forms

The State DMH will provide a clean copy of the MHSIP Consumer Survey to the county evaluator. The county Evaluator will make clear copies to distribute to staff.

MHSIP Consumer Survey

This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

INSTRUCTIONS: This survey will help us to improve our mental health services for you. Your answers will be kept confidential and will only be used to evaluate and improve the services here. Please indicate your agreement or disagreement with each of the statements below. Fill in the circle that best represents your opinion.

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

County

0 1 2 3 4 5 6 7 8 9

Link Date (mm-dd-yyyy)

0 1 2 3 4 5 6 7 8 9

		Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1.	I like the services that I received here.	○	○	○	○	○	○
2.	If I had other choices, I would still choose to get services from this agency.	○	○	○	○	○	○
3.	I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4.	The location of services was convenient *(parking, public transportation, distance, etc.)*	○	○	○	○	○	○
5.	Staff were willing to help as often as I felt it was necessary.	○	○	○	○	○	○
6.	Staff returned my calls within 24 hours.	○	○	○	○	○	○
7.	Services were available at times that were good for me.	○	○	○	○	○	○
8.	I was able to get all the services I thought I needed.	○	○	○	○	○	○
9.	Staff here believed that I could grow, change, and recover.	○	○	○	○	○	○
10.	I felt safe to raise questions or complain.	○	○	○	○	○	○
11.	Staff told me what side effects to watch for.	○	○	○	○	○	○
12.	Staff respected my wishes about who is, and is not, to be given information about my treatment.	○	○	○	○	○	○

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	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
13. Staff were sensitive to my cultural/ethnic background.	○	○	○	○	○	○
14. Staff helped me so that I could manage my life and recover.	○	○	○	○	○	○
15. I felt that I was treated with respect by the receptionist.	○	○	○	○	○	○
16. I felt comfortable asking questions about my treatment and medication.	○	○	○	○	○	○
17. Staff and I worked together to plan my treatment.	○	○	○	○	○	○
18. I, not staff, decided my treatment goals.	○	○	○	○	○	○
19. I was given written information that I could understand.	○	○	○	○	○	○

As a Direct Result of Services I Received:

20. I deal more effectively with daily problems.	○	○	○	○	○	○
21. I am better able to control my life.	○	○	○	○	○	○
22. I am better able to deal with crisis.	○	○	○	○	○	○
23. I am getting along better with my family.	○	○	○	○	○	○
24. I do better in social situations.	○	○	○	○	○	○
25. I do better in school and/or work.	○	○	○	○	○	○
26. My symptoms are not bothering me as much.	○	○	○	○	○	○

27. How did you become involved with this program?

○ I decided to come in on my own.
○ Someone else recommended I come in.
○ I came in against my will.

28. What would you like to see changed about this program? (Write comments in box below)

29. Do you currently attend self-help?

○ Yes ○ Not Available ○ No

30. If YES, how often do you participate?

○ Daily ○ Weekly ○ Monthly ○ Occasionally

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Chapter 8
Summary of County Evaluator's Responsibilities

General Information
The county evaluator is the keystone of a successful evaluation of the Supportive Housing Project. This person has critical data collection and evaluation responsibilities that have been described in previous chapters. This chapter provides a summary of each of the tasks that are the responsibility of the county evaluator.

Responsible for County Data Collection
The county evaluator is the person designated by the county as the person responsible for the county 's Supportive Housing evaluation efforts. As the "Point Person" for the county's evaluation efforts, the county evaluator is the person who will be contacted when there are problems with the county evaluation and who will be expected to resolve the issues.

Making Copies of The Manual
In preparation for training project staff on the administration of the instruments, the county evaluator will make copies of the Evaluator's Training Manual, the CA-QOL scoring manual and the Instruction Sheet for the K Axis.

Training Project Staff
Training project and clinical staff on the administration of the forms and the evaluation procedures is the next tasks for the county evaluator. Training the staff will, hopefully, help them understand the importance of their role in the data collection and will ensure accurate data.

Developing Client Tracking System
The county evaluator will need to develop a tracking system in order to identify when clients enter the program, when they are due for an annual assessment or a discharge assessment. Since the evaluator is responsible for distributing the correct set of forms, the evaluator will need to have a system to track clients who are approaching their annual assessment or who are about to be discharged.

Tracking Data Collection
Data collection on each project will be overseen by the county evaluator. If there are problems with tardy data collection or forms completed incorrectly, it will be the county evaluator's responsibility to correct these problems. As part of this tracking of data collection, the county evaluator will make sure that a Consent to Participate (or decline) form is on file for every project participant.

Preparing Forms for Staff

The county evaluator will prepare the appropriate set of evaluation forms for the type of assessment. As discussed in Chapter 2, different assessment periods use a different combinations of forms. Table 8.1 lists the forms that should be completed for each assessment type.

TABLE 8.1 Administration Schedule for Housing Evaluation Forms

ADMISSION	ANNUALLY	DISCHARGE - CLIENT AVAILABLE	DISCHARGE - CLIENT UNAVAILABLE
Consent to Participate			
Face sheet	Face sheet	Face Sheet	Face sheet
K Axis	K Axis	K Axis	
CA-QOL	CA-QOL	CA-QOL	
	MHSIP Consumer Survey	MHSIP Consumer Survey	

On the Face sheet, the county evaluator will complete the client I.D. number, county code, distribution date, assessment type, and form linking number in the appropriate fields. These are described in Chapter 4.

On the K Axis, the evaluator will complete the fields for distribution date, client I.D. and the county code. This is discussed in detail in Chapters 4 and 5.

For the CA-QOL and the MHSIP Consumer Survey, the evaluator will complete the client I.D., distribution date, county code and form linking number. This is discussed in Chapters 4, 6, and 7.

The county evaluator will also preaddress and stamp the envelopes which are handed out with MHSIP Consumer Survey. This is discussed in Chapter 7.

Distributing Forms to Staff

Once the packet of forms is prepared with the identification fields completed, the county evaluator will distribute the forms to the appropriate staff. Note that the K Axis must be distributed to a clinician. This is discussed in detail in Chapter 5.

Ensuring Qualified Staff Administer Forms

It is imperative that only staff trained in administering the forms are allowed to do so. If there is staff turnover, the county evaluator will need to train the new staff.

It is also the responsibility of the county evaluator to ensure that qualified clinical staff administer the K Axis. This is discussed in Chapter 5.

Maintaining File for Consent Forms

Consent (or decline) to participate forms will be maintained in a separate file from clinical records. This file will be maintained by the county evaluator in a locked cabinet. This file will be made available for inspection by State DMH when requested

Being Important

The county evaluator is the key person in the evaluation efforts. If the data are bad, little can be said about the program's effectiveness and consumer reactions. Good data start with the county evaluator and well trained and committed staff. Filling out the forms is burdensome but it is a small price to pay for the federal money. Good follow-up data provide support and rationale for additional funds. The critical person in all of this is the county evaluator. The state Department of Mental Health and the consumers thank you for your efforts.

GOOD LUCK!

APPENDIX A
COUNTY CDS / CSI CODES

01	=	Alameda	22	=	Mariposa	43	=	Santa Clara
02	=	Alpine	23	=	Mendocino	44	=	Santa Cruz
03	=	Amador	24	=	Merced	45	=	Shasta
04	=	Butte	25	=	Modoc	46	=	Sierra
05	=	Calaveras	26	=	Mono	47	=	Siskiyou
06	=	Colusa	27	=	Monterey	48	=	Solano
07	=	Contra Costa	28	=	Napa	49	=	Sonoma
08	=	Del Norte	29	=	Nevada	50	=	Stanislaus
09	=	El Dorado	30	=	Orange	51	=	Sutter
10	=	Fresno	31	=	Placer	52	=	Tehama
11	=	Glenn	32	=	Plumas	53	=	Trinity
12	=	Humboldt	33	=	Riverside	54	=	Tulare
13	=	Imperial	34	=	Sacramento	55	=	Tuolumne
14	=	Inyo	35	=	San Benito	56	=	Ventura
15	=	Kern	36	=	San Bernardino	57	=	Yolo
16	=	Kings	37	=	San Diego	58	=	Yuba (Sutter/Yuba)
17	=	Lake	38	=	San Francisco			
18	=	Lassen	39	=	San Joaquin	63	=	Sutter/Yuba
19	=	Los Angeles	40	=	San Luis Obispo	65	=	Berkeley City
20	=	Madera	41	=	San Mateo	66	=	Tri-City
21	=	Marin	42	=	Santa Barbara			

APPENDIX B- PSYCHOMETRICS

General Information

The term "psychometrics" refers to the practice and technology of applying statistically-based techniques toward the measurement and understanding of psychological "events". These events could include attitudes, personality traits, aptitudes and abilities, and underlying factors relating to psychological functioning. In a clinical setting, which by design is generally centered on a specific individual, some feel that using statistically based assessment tools is not appropriate. Rather, these individuals feel that it is the clinician's professional judgment which grows out of the establishment of a relationship of mutual trust that is most important.

No reasonable psychometrician would claim that statistical data is more important than the relationship that exists between service provider and client. However, psychometric data can, if used appropriately, provide a very valuable piece of the puzzle that helps the clinician to develop a more complete picture of the client. Specifically, **psychometric data provides three essential components to the diagnosis, treatment planning, and service provision process**:

1) Well Defined Areas of Measurement

Scores that are derived from appropriately designed psychometric-based assessment instruments are generally well defined so that something meaningful can be said about a person based on his or her score on that instrument.

2) Reliability

There is evidence that the diagnostic process, when based on clinician judgment alone, is not particularly reliable. In other words, if several clinicians evaluate the same client using the same information, their diagnoses will likely differ to some degree. To the extent that specific diagnoses are more amenable to specific treatment modalities, arriving at an appropriate diagnosis is critical to providing the best service to clients. With psychometric-based data, it is possible to state, in a quantifiable way, how much confidence may be placed in scores that describe the client. This is not to say that those scores are necessarily a complete picture of the client, however. But when psychometric data are used in conjunction with a clinicians clinical judgment, greater confidence may be placed in the overall treatment planning process.

3) Validity

The third and final essential component that psychometric data brings to the diagnosis, treatment planning, and service provision process is a quantifiable level of validity. Because of the intimate and person-centered nature of the clinician-client relationship, a wide variety of factors enter into the judgments made by the clinician about the client. For example, the nature of the clinician's training will guide diagnostic procedures, and will likely lead to a focus on client behaviors that

were emphasized in his or her training; the clinician's own recent and overall professional experience will affect how he or she approaches the client; because the clinician is human, it is likely that his or her own emotional state and personal beliefs will affect judgments made about the client; finally, the administrative environment in which the clinician works will likely place constraints on how the clinician-client relationship develops.

Because of the way that psychometric-based assessment instruments are developed, it is possible--within limits--to be sure that the instrument is mainly measuring what it is supposed to measure. This is referred to as "instrument validity." Stated in other terms, validity refers to the extent to which an instrument is measuring what it is supposed to measure and that the clinician can make appropriate judgments based on the instrument score(s).

Some Basic Concepts in Psychometrics

Reliability

Broadly defined, reliability simply refers to the confidence that you can have in a person's score. In some cases, you want to be able to have confidence that the individual would have the same score over time. This is because you have reason to believe that what is being measured should not change over time. For example, if a person passes a driving test in January it is hoped that the same individual would pass the test one year later. At other times, it may not be appropriate to expect that scores would remain consistent over time. For example, it is hoped that if a client receives treatment for depression, the score that the client would receive on a measure of depression should decrease over time. Psychometricians and other measurement specialists have developed various methods of establishing reliability to meet these varying needs. Some of these are listed below:

Test-Retest Reliability

In test-retest reliability methodologies, an assessment instrument is administered at time 1 and then again at some later date(s). To the extent that the scores that the client receives are the same on both administrations, the two sets of scores will be positively correlated. The correlation coefficient between these two administrations then becomes an estimate of the ability of the assessment instrument to reliably assess the client over time.

Problems with this approach: The main problem with the test-retest approach to establishing validity is that a wide variety of intervening variables can come into play between the first and subsequent administrations of the instrument. An example from the educational setting might be that a college entrance examination is administered to students at the beginning of their Junior year of high school. If the same instrument were administered again at the end of those same students' senior year, the scores would likely be quite different due to all of the intervening

learning that took place. From a psychological standpoint, if a person completed a measure of depression at time one and them experienced some major life event before the second administration of the measure, the estimate of the instrument's reliability would appear low. Finally, it is possible that, having completed the instrument one time the clinician's or client's responses may be affected at the second administration if he or she remembers the previous responses.

If, on the other hand, it is hypothesized that whatever the assessment instrument is measuring really should not change over time, then the test-retest approach is a powerful method of establishing this fact.

Parallel Forms Reliability

Another way of establishing reliability is to develop two forms of the same instrument. In theory, if the two forms are measuring the same thing (e.g., depression), then the scores on the two forms should be highly and significantly correlated. To the extent that they are in fact correlated, the correlation coefficient is roughly a measure of parallel forms reliability.

Problems with this approach: There are several problems with this method of establishing reliability. First, it can be expensive to develop two parallel forms. The second and perhaps greater problem is that there is always a certain amount of "criterion contamination" or variance that is unrelated to what is intended to be measured in an instrument score. This is compounded in that if there is a certain amount of unsystematic variance in each assessment instrument, then the sum of that variance across the two forms will reduce the reliability between the forms.

Split-Half Reliability

This method of establishing reliability is similar to the parallel forms method--but with one important difference. To use the split-half method, an assessment instrument is administered to a group of individuals. Next the instrument is essentially randomly divided into to equal portions. These two portions are then evaluated to examine how strongly they are correlated. Assuming that the instrument is measuring a common trait, ability, or psychological dimension, each half of the randomly divided instrument should be a measure of the same thing. Therefore, scores on each half should be highly correlated.

Problems with this approach: There are two main problems with this approach. First, when you divide the assessment instrument in half, you effectively reduce the number of items from which the total score is calculated by half. Thus, you may by nature have a score on each half that is of lower reliability and therefore any correlation between the two halves could be reduced. Therefore, the overall estimate of reliability could appear inappropriately low. The second problem is that even though the assessment instrument was randomly divided, there is no guarantee

that the two halves are actually equivalent. To the extent that they are not, the estimate of overall reliability will be lower.

Internal Consistency

The internal consistency approach to establishing reliability essentially evaluates the inter-item correlations within the instrument. Ultimately, an estimate of reliability is generated that is equivalent to the average of all possible split-half divisions that could have been made for that instrument.

TABLE B-1: Summary of Reliability Methodologies

Method	Strengths	Weaknesses
Test-Retest Reliability	• Correlates scores from two separate administrations of an instrument. • Correlation coefficient estimates instrument's ability to reliably assess client over time.	• A wide variety of intervening variables between the first and subsequent administrations of the instrument could alter the results.
Parallel Forms Reliability	• Correlates scores of two forms of an instrument designed to measure the same thing. • Correlation coefficient estimates instrument's ability to measure the target domain.	• It can be expensive to develop two parallel forms. • There is always a certain amount of variance unrelated to what is intended to be measured in an instrument score that would reduce the reliability between the forms.
Split-Half Reliability	• Correlates scores for two equal, randomly divided portions of an instrument. • Correlation coefficient estimates instrument's ability to measure the target domain.	• Since only 50% of the items are used per score, the overall estimate of reliability could appear inappropriately low. • To the extent that the two halves are not equivalent, the estimate of overall reliability will be lower.
Internal Consistency	• Evaluates the inter-item correlations within the instrument. • An estimate of reliability is generated equivalent to the average of all possible split-half divisions.	

Validity

Some people misuse the term "validity" when they refer to assessment instruments. It is inappropriate to say that an assessment instrument is valid. Rather, it is the inferences or decisions that are made on the basis of an instrument's scores that are either valid or

invalid. In order to be able to make valid inferences about a client based on his or her score on an instrument, the instrument must be measuring what it was intended to measure. This point cannot be emphasized enough.

When a client completes an instrument that is designed to evaluate his or her psychological functioning, if the instrument uses terms that, while common in a European cultural setting, may not be familiar in an Asian setting, then the inferences based on the instrument scores may not be appropriate for Asians. Threats to validity do not have to be nearly so extreme or obvious to make interpretation of scores invalid for making assessments. Therefore, it is important for users of test information to understand methods of test validation, the strengths and weaknesses of each, and what types of inferences are more appropriate for the method of validation that was used. Several validation methods are discussed briefly below.

Content Validity

When one says that an instrument is content valid, it indicates that the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. For example, in an instrument designed to measure quality of life, if that instrument contains items such as indicators of living situation, independence, self-sufficiency, etc. (assuming these have been documented by a group of individuals as measuring quality of life), then the instrument may arguably be called "content valid."

Criterion-Related Validity

There are basically two methods of employing criterion-related validation strategies. These are: a) predictive and b) concurrent.

In predictive criterion-related validation strategies, the goal is to develop an instrument that is able to predict a persons later score, performance, or outcome based on some initial score. Examples of such predictive instruments include the General Aptitude Test Battery (GATB), Armed Services Vocational Aptitude Battery (ASVAB), Scholastic Aptitude Test (SAT), and Graduate Record Examination (GRE).

In concurrent criterion-related validation strategies, the goal is to effectively discriminate between individuals of groups on some current trait. For example, the Minnesota Multiphasic Personality Inventory (MMPI) was developed using a method called criterion keying to develop an instrument that was extremely powerful at identifying whether or not a person was currently experiencing psychoses.

The criterion-related validation approach can be extremely powerful. However, it suffers from a variety of conceptual and/or logistical problems. Although I will

not delve deeply into the statistical reasons for these problems, I will list them. Using a criterion-related validation strategy:

- It is difficult to develop parallel forms.
- Instruments tend to have low internal consistency.
- To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion. This makes it methodologically difficult to identify test items.
- Instruments tend to have low face validity.

Construct Validity

Construct validation approaches utilize factor analysis to identify items that appear to be highly correlated to one another. To the extent that items are, in fact, correlated to each other they are assumed to be measuring something in common. Exactly what those items are measuring is difficult to say. What test developers do is review the content of the items and try to identify commonalties in the subject matter that they cover. For example, if a group of inter-correlated items addresses such things as sleeplessness, lack of energy, frequent crying, fear of being alone, etc., a test developer may decide that these items are measuring the construct of depression.

What is a construct? It is important to keep in mind that a construct does not exist. Rather, it is a theoretical creation to explain something that is observed. Returning to our example of a depression construct, depression is not a thing that exists. Rather, it is simply a name that we have given to a group of traits or a level of psychological functioning.

Face Validity

Face validity simply refers to the extent to which an assessment instrument "appears" to be related to what it purports to measure. For example, a driving test is face valid because all of the questions that are asked are related to laws and situations that a driver may be faced with. Therefore, even if we don't like driving tests, most of use feel that they are at least somewhat related to driving.

On the other hand, someone may find that math ability is related to driving ability. If this occurred, it would be possible to administer a math test and, based on the scores a test taker received, either approve or deny a drivers license. In this case, a math test could be valid for use in predicting driving behavior, but it would not be face valid because it would "appear" unrelated to the task of driving.

Face validity is important in most assessment settings because people inherently like to make sense out of what they are doing. When clinicians, clients, family members, or anyone else are asked to fill out an assessment instrument, they will

feel better about doing so and will likely provide more accurate data if they feel that the information they provide makes sense and can see how it can be useful.

TABLE B-2: Summary of Validation Methodologies

Method	Strengths	Weaknesses
Content Validity	• Provides an indication of how the individual items that make up the instrument are reflective of the specific domain that they are intended to measure.	• Assumes that the area being measured is clearly understood. • To the extent that what is being measured is conceptual or multi-dimensional, effective content-oriented items may be difficult to develop.
Criterion-Related Validity	• *Predictive strategies* provide an indication of how well the instrument is able to predict a later score, performance, or outcome based on some initial score. • *Concurrent strategies* provide an indication of how the instrument effectively discriminates between individuals or groups on some current trait.	• It is difficult to develop parallel forms using this approach. • Instruments tend to have low internal consistency. • To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion making it methodologically difficult to identify test items. • Instruments tend to have low face validity.
Construct Validity	• Utilizes factor analysis to identify items that appear to be highly correlated to one another in order to develop assessment instruments that measure a common construct.	• Exactly what a group of inter-correlated items is measuring may be difficult to ascertain.
Face Validity	• Provides an indication of how the assessment instrument "appears" to be related to what it purports to measure	• Not really an indicator of validity. Rather, it is based on the assumption that data will be more valid when respondents see the relationship between the instrument and what it is supposed to measure.

Conclusion

Psychometric data is intended to provide an additional tool for clinicians and other service providers to use as they plan and conduct their treatment. It is not intended to supplant or replace clinical judgment. The above issues have been discussed to help those who use data generated from the Children and Youth Performance Outcome System evaluate and make more effective and appropriate use of their client's assessment data.

It is important to understand which method was used to validate each of the clinical assessment instruments so that you can know what kinds of judgments may be made about the scores. Knowing that an instrument is reliable and how the reliability was established can help the clinician have confidence in the scores as well as know what kinds of changes are reasonable to expect.

Finally, the remainder of this training document goes into additional detail on each of the assessment instruments. Each instrument's validity, reliability, administration and scoring procedures, interpretation, and use will be discussed. The above information is intended to help you make sense of this.

Sources of Further Information

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